Chapter 4: Meeting Basic Needs

This chapter discusses the extent to which juvenile facilities meet basic needs in terms of adequate living space (Section A), medical services (Section B), food, clothing, and hygiene (Section C), and living accommodations (Section D).

A. Living Space

Section A considers three measures of the adequacy of living space—square feet per juvenile in sleeping rooms, size of living units (measured by the number of juveniles housed within living units), and facility population as a percent of reported design capacity. It examines the variation in square feet per juvenile in sleeping rooms with different occupancy levels in different types of facilities, and describes recent trends in facility-wide crowding. The section shows how many juveniles would need to be removed or how many new confinement beds would need to be provided to eliminate crowding. Finally, it examines the relationship between crowding and injury rates and makes three recommendations.

There are a number of studies of the relationship between crowding and stress or behavior in correctional facilities. Most, but not all, are based on adult facilities. A summary of recent research in Toch (1985) suggests that crowding—particularly in multiple occupancy living units—is powerfully, but indirectly, linked to changes in negative behaviors or indicators of stress among residents.

Crowding reduces residents' ability to control, predict, and regulate interactions with other residents. As their ability to regulate unwanted contacts declines, their anxiety and hostility increases, and they become less tolerant of frustration. Crowding also affects patterns of activities in prisons, so that inmates spend more time in their cells and have less access to programs (Toch, 1985).

Dominance hierarchies among residents develop in any institution, partly to control allocation of desired but scarce resources. Crowding in adult prisons has been found to promote aggression-based dominance hierarchies by destabilizing both inmate social systems and organizational control systems (Toch, 1985).

Adult prisons are also destabilized by crowding because officials often grant early release to larger numbers of nonviolent inmates (Toch, 1985). Faster population turnover is itself a destabilizing influence, but in addition, early release of nonviolent offenders increases the proportion of violent offenders.

Crowding in adult prisons has also been found to change the nature of staff-inmate interactions. In crowded facilities, staff-to-inmate ratios are usually lower; when that happens staff and inmates interact less often, and the interactions that do occur tend to focus more on maintenance of order and authority than on provision of support or assistance (Toch, 1985).

Finally, the analysis in Chapter 8 indicates that the incidence of juvenile violence, both toward other juveniles and toward staff, is significantly higher in crowded conditions.

There is no constitutional standard on crowding in juvenile facilities. In *Morales* v. *Turman*[1] the trial court held that a constitutional right to treatment existed, which required conditions in facilities

[1] 383 F.Supp 53 (1974).

to meet certain standards, including freedom from unnecessary confinement in close quarters.[2] In a later action on this case, the court of appeals declined to endorse the concept of a constitutional right to treatment[3] but noted that any constitutional abuses found to exist could be remedied without endorsing the concept of a constitutional right to treatment.

The United States Supreme Court established a constitutional standard for adult facilities in *Rhodes* v. *Chapman*. In that case, the Court held that conditions in prisons "must not involve the wanton and unnecessary infliction of pain, nor may they be grossly disproportionate to the severity of the crime warranting imprisonment."[4] This case involved an Ohio adult prison considered to be a model facility in all ways, except that it was operating at 38 percent above its design capacity, and double-bunked inmates had only about 33 square feet of floor space each in their cells. The Supreme Court found that, in this instance, crowding did not lead to deprivations of food, medical care, or sanitation, or a rise in inmate violence, and thus did not "create . . . conditions intolerable for prison confinement."[5] In later adult cases where the positive features of the Ohio prison were not present, lower courts have found conditions to be unconstitutional under *Rhodes* v. *Chapman*.

It is not clear whether the Supreme Court would apply the constitutional standard in *Rhodes* v. *Chapman* to juvenile facilities. In detention centers, at least, juveniles are held prior to adjudication, so, as Soler notes, "the applicable standard would be whether the conditions amounted to 'punishment' in violation of the due process clause of the 14th amendment, rather than whether the conditions constituted wanton and unnecessary infliction of pain, in violation of the 8th amendment."[6] It is also possible that the Supreme Court might conclude that conditions found minimally tolerable for adults would be damaging for children.

The Measurement and Consequences of Crowding

We measure crowding by comparing facility capacity with its population on a specific day. Crowding occurs when a facility's population exceeds its capacity. Populations, of course, vary from day to day and month to month. However, these variations in population seem unlikely to have an important effect on our results.[7] Random variations in population mean that a given facility may be crowded on one day and not the next. Overall, however, we expect that these fluctuations will cancel each other; the specific institutions that are crowded may change, but over the short term the total number of crowded institutions will tend to stay the same. Systematic variations may affect our assessment of crowding. We use the data on population collected by the CIC census for Friday, February 15, 1991. Thus, we are likely to underestimate somewhat the extent of crowding in detention centers during weekends, because detention center populations tend to rise on weekends. Likewise, training schools may

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[2] The testimony on which this point focused was mostly on the use of dormitories housing 40 to 50 juveniles, whose beds were tightly packed together.

[3] *Morales* v. *Turman* 562 F.2d 993 (1977).

[4] 452 U.S. 337, 101 S. Ct. 2392, 69 L.Ed. 2d 59 (1981).

[5] Id. at 347.

[6] Soler, *Representing the Child Client*, (1990).

[7] We compared analyses based on both measures of population size and essentially found no difference between the results at the level of facility type.

be somewhat less crowded in summer than our data indicate because training schools' populations tend to be lower in summer.

Measuring capacity is more difficult. While we focus on living space, capacity can be measured in a number of ways, including, for example:

- The occupancy level for which an architect designed a facility.
- Occupancy limits set by building inspectors based on the current condition of a facility's mechanical systems.
- Occupancy limits determined by applying sanitation code formulas to the number of showers or toilets in juveniles' living areas.
- The number of beds in the facility.

The extent of crowding may involve more than simple measures of physical capacity. Practitioners note that many factors aggravate or mitigate the effects of physical crowding. The effects may be less severe if juveniles are confined in small rooms only while they sleep, and if the overall quality of conditions is good. Expanding on this concept, some practitioners suggest that facilities are affected by crowding when their ability to perform important functions is impaired due to rising populations. For example, classification is, among other things, supposed to protect residents by separating them into different living areas based on their propensity to violence or vulnerability to victimization. As a facility's population rises (assuming, of course, its capacity is constant), it becomes harder to implement the separation required by classification because there are fewer empty beds. Similarly, it becomes harder to repair or maintain sleeping rooms because they are often not vacant long enough to complete the work. Some practitioners maintain that classification and maintenance become impaired when a facility's population reaches about 80 percent of design capacity (Klofas, 1992). Others set that figure slightly higher—at 85 to 90 percent of design capacity.

This functional view of capacity suggests that crowding should be understood in terms of its effects on all aspects of facilities, from provision of basic services to programming to staffing. As population increases, more clothes must be purchased, stored, and washed; more food must be bought, stored, and cooked; more hot water must be provided for showers, cooking, and laundries; and more waste water must be disposed of. More juveniles need to be educated, even if the capacity of an education program is fixed by the number of classrooms available or by student-teacher ratios specified in teachers' contracts. More health care services will be required. More security staff will be needed; if the number of staff is reduced or the staff-to-juvenile ratio increased, juvenile-on-juvenile violence may rise, and more residents may join gangs for protection. Declining staffing coverage may also lead to greater use of overtime to provide coverage, increased staff burnout, and higher turnover rates, which, in turn, may increase staff recruitment and training costs.

Crowding also can occur within a facility and affect only a small portion of an entire institution. For example, a facility may have a capacity of 100 with a population of 90, but have 20 females living in one unit designed for 15 inmates.

We cannot reasonably hope to assess facilities' overall functional capacity. As a result, our assessment measures focus on living space as reflected in: (a) square feet per juvenile in sleeping rooms, (b) maximum size of living units, and (c) population as a percent of reported design capacity.

a) Square feet per juvenile in sleeping rooms

ACA standards require that juveniles confined in one-person sleeping rooms have 70 square feet of floor space and that juveniles confined in sleeping rooms housing three or more juveniles have 50 square feet per juvenile.[8] ACA standards are silent on minimum square footage requirements for sleeping rooms housing two juveniles. Our assessment criteria are congruent with ACA standards for single rooms and for rooms with three or more occupants. We selected 70 square feet per juvenile as the criterion for double-occupancy sleeping rooms.

To some extent, our selection of 70 square feet represents an arbitrary choice. We could have, perhaps, selected 60 square feet as an interpolation between the 70-square-foot standard for single rooms and the 50-square-foot standard for rooms with three or more juveniles. While this is consistent with the logic that the required minimum space per juvenile declines, somewhat, as the number of juveniles increases from one to three, we would be defining a new figure for room size not expressed in any existing nationally recognized standard. Moreover, court cases—to the limited extent they have dealt with room size issues—have supported minimum room sizes equal to or larger than the ACA 70-square-foot level.[9]

The mail survey asked respondents to record the average square feet per juvenile in rooms by occupancy category—that is, for rooms housing 1, 2, 3 or 4, 5 to 10, and 11 or more juveniles. In addition, respondents entered the number of juveniles housed in each occupancy category on the date of the survey. We use these facts to determine whether the facility provided 70 square feet or more per resident for one- or two-person rooms and 50 square feet or more per resident in rooms with three or more persons. We assess a facility as crowded if the average square feet per resident in any occupancy category is less than the minimum for that category. We count the proportion of juveniles in a facility who are in crowded sleeping units by classifying all juveniles in an occupancy category as crowded or uncrowded based on the average square feet per juvenile in that category. These measures are clearly subject to some error. A facility may have some crowded sleeping units even though the average square feet per resident in each occupancy category is adequate. Conversely, inadequate average square feet in an occupancy category need not indicate that every sleeping unit in that category is inadequate.[10] Based on site visits, it appears that in most facilities, room dimensions within the different occupancy categories usually were very similar. For example, within a facility, all single-occupancy rooms usually were the same size. Thus, if the average room size is less than that required by the assessment criteria, it is probable that all juveniles who sleep in those rooms are confined in rooms that are smaller than required. This generalization does not apply, however, to facilities in which different units of the facility were constructed at different times. In this situation, for example, sleeping rooms in an older living unit may

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[8] IJA/ABA standards call for 100 square feet per juvenile in all sleeping rooms, regardless of the number of juveniles who share the rooms.

[9] *F.E.* v. *Hensley*, Civil Action No. 73 CV 43-W-1 (W.D. Mo., Dec. 15, 1978); *Ahern* v. *Thomas*, 434 F.Supp. 873; 570 F.2d 286 (8th Cir. 1989).

[10] On a mail survey we could not ask facility administrators to individually measure and report the dimensions and occupancy levels of every sleeping room in their facility. Hence, we asked them to report the average square feet in rooms with different occupancy levels and to report the number of juveniles in their facility residing in rooms within each occupancy category. Based on information from practitioners and pretests of the mail survey, this appeared reasonable. Practitioners assured us that most facility administrators would know the average square footage of sleeping rooms with different occupancy levels.

be smaller than specified by the assessment criteria, while those in a newer unit may be larger; but on average, the rooms may slightly exceed the square footage per juvenile specified in the assessment criteria.

b) Size of living unit

A living unit is an area of a facility that contains sleeping rooms, toilet and bathing facilities, and common-use areas, such as recreation rooms and multipurpose rooms. In very small facilities, programming (like education and treatment) may occur within the living unit. Usually, however, programming occurs in other areas of the facility. Small living units are supposed to make facilities more manageable and less institutional in character. Small living units reduce social density and thus better enable residents to avoid unwanted contacts with other juveniles. Programming delivered in small living units involves more personal interaction between staff and juveniles. The assessment criteria require that living units not exceed 25 juveniles.[11] The mail survey asked respondents to list the population of their largest living unit. If the largest living unit had 26 or more residents, the facility did not conform.

We cannot determine the proportion of juveniles in large sleeping units from mail survey data. The mail survey collected information on the sizes of the largest and smallest living units and allowed us to compute the average living unit size. Based on these data, it is clear that living unit sizes often vary considerably.[12] We can use mail survey data to estimate upper and lower bounds on the proportions of juveniles in large living units. Site visit data also can be used to provide estimates for all facilities.

c) Population equal to or less than reported design capacity

Crowding can also be measured by comparing the population of a facility with the capacity for which it was designed. We obtained reported design capacity levels for each facility from the CIC census. It asked for the number of juveniles the facility was constructed to house without crowding. The CIC census provided examples of crowding: double-bunking in sleeping rooms designed for one person or temporarily using as a sleeping room an area that was designed for some other use. The CIC census does not provide an explicit and unambiguous definition of design capacity. Hence, it is likely that different facilities or different jurisdictions used different definitions of design capacity when responding to the CIC census. A more reliable measure would require an objective and unambiguous definition and an independent inspection of each facility by carefully trained auditors to ascertain its capacity. That effort was beyond the scope of this study. Whatever its limitations, reported design capacity was available for all facilities from the CIC census.

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[11] This is the figure specified in ACA standards. The Institute for Judicial Administration/American Bar Association standards call for no more than 20 residents in a living unit.

[12] We did not ask mail survey respondents to record the population of each living unit in the facility. Some large facilities had nearly 40 living units, and we did not want to devote so much of the mail survey to data on living unit size. During site visits we saw substantial variation in population among living units. In detention centers, for example, girls' units usually had substantially fewer residents than units housing boys. In training schools, segregation units typically had fewer residents than regular living units, while the population of self-contained treatment programs housed within a living unit often varied (sometimes larger, sometimes smaller) substantially from those of regular living units. Where parts of facilities were constructed at different times, there often were substantial differences in the capacities and populations of living units in different cottages or areas.

Hence, using reported design capacity to assess facility-wide crowding could introduce some reporting error. Prior studies of adult facilities (see *American Prisons and Jails*, 1978) found substantial variation in facilities' reported design capacity when measured against objective criteria.

During site visits we asked administrators several questions to clarify the reliability of reported design capacity as a measure of crowding. We first asked administrators if their facility had ever experienced problems with overcrowding. Sixty-five percent said yes. Almost two-thirds of the facilities with past crowding were over capacity on the date of the CIC census. In addition, only 15 percent of the facilities we visited that were over capacity on the date of the CIC census said they had not experienced crowding in the past. We also found that facilities whose population was over design capacity on the date of the CIC census were more likely to have taken overt steps to expand capacity. For example, 58 percent of those over capacity on the date of the CIC census had added bunks to existing sleeping rooms, compared to 9.6 percent of those whose population was below capacity on the date of the CIC census. Hence, despite the lack of uniform definition, we believe that when facilities report that their population exceeds design capacity, their response is a generally reliable indicator of crowded conditions.

Results

Table 4A-1 shows the percentage of juveniles in facilities that conform to each of the assessment criteria. These figures reflect the overall assessment for the facility. Subsequent tables present information on the percentage of juveniles in crowded sleeping rooms or large sleeping units.

Overall, 53 percent of juveniles are in facilities whose sleeping rooms are, on average, adequately sized, 49 percent are in facilities where all living units have 25 or fewer residents, and 53 percent are in facilities where the population does not exceed reported design capacity. Only 24 percent are in facilities that are adequate in terms of all three criteria. In general, juveniles in ranches are somewhat more likely to be in facilities with uncrowded conditions. Juveniles in reception centers are less likely to be in uncrowded facilities, especially in terms of living unit size and design capacity.

Interestingly, while the three criteria are associated to some degree, there is a stronger association between inadequate square feet per juvenile and large living units (correlation = 0.32) or population above capacity and large living units (correlation = 0.36) than between inadequate square feet per juvenile and population above capacity (correlation = 0.20). This probably reflects the fact (discussed further below) that some facilities were apparently designed with small sleeping rooms (as evidenced by, for example, single-occupant rooms with fewer than 70 square feet).

These figures suggest that crowding is a widespread and serious problem. Further exploration of each assessment criterion, reported below, supports this conclusion. Indeed, it appears that eliminating crowding would require either a very substantial reduction in the population of confined juveniles or a substantial expansion of juvenile confinement capacity.

Size and Configuration of Sleeping Rooms. Room size and configuration is the first of three levels on which the adequacy of living space is considered.

Table 4A-1

Percent of Juveniles in Facilities That Conform to Assessment Criteria on Living Space, 1991*

Assessment Criteria	Detention Centers (N=18,140 -19,579)	Reception Centers (N=2,305 -2,618)	Training Schools (N=30,019 -33,895)	Ranches (N=5,217 -6,981)	Total (N=55,681 -62,582)
Min. sq. feet in sleeping rooms[a]	**59%**	**55%**	**46%**	**66%**	**53%**
Max. of 25 per living unit[b]	**53%**	**28%**	**46%**	**60%**	**49%**
Population not more than design capacity[c]	**47%**	**32%**	**53%**	**83%**	**53%**
Percent of juveniles in facilities that: Conform to all three criteria	26%	14%	23%	31%	24%
Conform to two criteria	20%	10%	22%	49%	24%
Conform to one criterion	40%	38%	25%	14%	30%
Conform to none of the criteria	14%	38%	29%	6%	23%

Source: Mail Survey, 1991

[a] For information on percent of facilities that conform, see Appendix E, Table E-1.
[b] For information on percent of facilities that conform, see Appendix E, Table E-2.
[c] For information on percent of facilities that conform, see Appendix E, Table E-3.

*Note: Throughout the report, the number of juveniles on whom the tables are based vary due to missing responses to individual questions. (No attempt was made to adjust for nonresponse.)

It is important to know about both the size of sleeping rooms and the distribution of juveniles in sleeping rooms with different occupancy levels. Crowding can be characterized in terms of spatial density—the number of square feet of floor space per juvenile, and also in terms of social density—that is, the number of residents who share a given area. In multiple-occupancy rooms, social density has a greater effect than spatial density on measures of stress and behavior.[13] However, as both spatial and

[13] Paulus, McCain, and Cox (1985).

social density increase at the same time, measures of stress and behavior are even more pronounced.[14] Other studies generally have concluded that measures of stress and behavior (such as blood pressure, stress-related chemicals present in urine, inmates' perceptions of crowding, incident reports, assaults,[15] suicides, illnesses,[16] and psychiatric commitments) vary directly with the number of persons who occupy a given living area.

Table 4A–2 shows the percentage of juveniles who sleep in rooms with different occupancy levels. Overall, 43 percent of confined juveniles sleep in single rooms, 24 percent sleep in double rooms, and 21 percent sleep in rooms housing 11 or more juveniles. Single rooms are the predominant occupancy level in detention centers, housing 70 percent of detained juveniles. Double rooms predominate in reception centers (59 percent of juveniles). Dormitory rooms with 11 or more juveniles are the most common occupancy level in ranches (42 percent of juveniles) and the second most common occupancy level in training schools (28 percent of juveniles).

Table 4A–2

Percent of Juveniles Sleeping in Rooms With Different Occupancy Levels, by Facility Type, 1991

Occupancy Levels	Detention Centers N=20,074	Reception Centers N=2,618	Training Schools N=34,898–35,102	Ranches N=7,023–7,180	Total N=64,770–64,974
1 juvenile	70%[a]	22%	36%	10%	43%
2 juveniles	20%	59%	23%	25%	24%
3–4 juveniles	3%	4%	8%	17%	8%
5–10 juveniles	4%	0%	4%	6%	4%
11 or more juveniles	3%	14%	28%	42%	21%

Source: Mail Survey, 1991

[a] ACA standards require that at least 80 percent of juveniles in detention centers be housed in single rooms.

[14] Studies of adult and juvenile correctional institutions have found little relationship between spatial density and measures of stress or negative behavior in single occupancy rooms. Single rooms, regardless of their size, permit residents to control and regulate unwanted social contacts.

[15] Jan, 1980; Gaes and McGuire, 1985; Megargee, 1977; Nacci, Prather, and Teitelbaum, 1977.

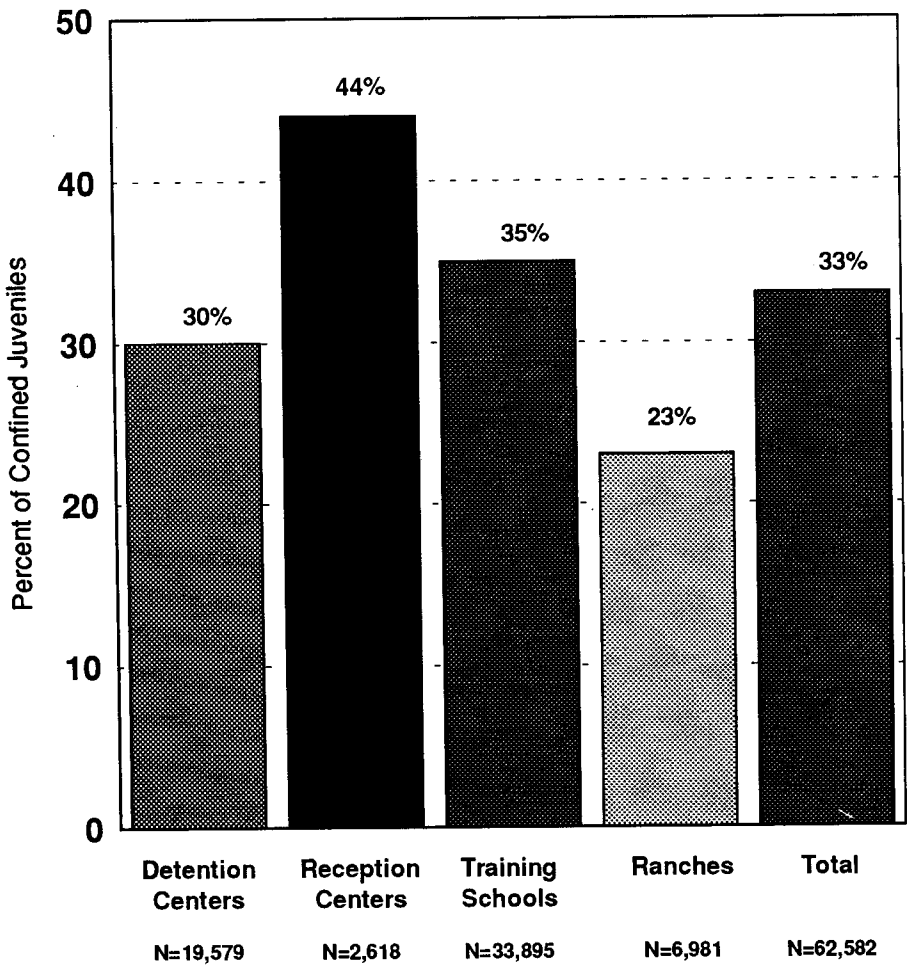
[16] Dubos,1965; Paulus, McCain, and Cox, 1985, 1978.

We classify a facility as crowded if any juvenile confined in the facility sleeps in an undersized room—that is, in a single or double room with less than 70 square feet per juvenile or in a room with three or more juveniles that contains less than 50 square feet per juvenile. While 47 percent of confined juveniles reside in facilities that have some crowded sleeping rooms, one-third of confined juveniles sleep in undersized rooms (Figure 4A–1).

Figure 4A–1 shows the percentage of confined juveniles who sleep in undersized rooms in each facility type. Overall, 33 percent sleep in undersized rooms, including 44 percent in reception centers, 35 percent in training schools, and 30 percent in detention centers.

Figure 4A–1

Percent of Confined Juveniles Who Sleep in Undersized Rooms



Source: Mail Survey, 1991

Table 4A-3 shows the distribution of juveniles who sleep in undersized rooms with different occupancy levels. In detention centers, 57 percent of juveniles in undersized rooms sleep in single rooms and 34 percent sleep in double rooms. By contrast, in training schools and ranches, juveniles in undersized rooms are most likely to be in double rooms or large dormitories. In training schools, 35 percent of those in undersized rooms sleep in large dormitories (housing 11 or more residents), while another 35 percent sleep in double rooms. In ranches, 44 percent are in undersized double rooms and 32 percent are in undersized large dormitories.

Table 4A-3

Percent of Juveniles Who Sleep in Undersized Rooms, by Occupancy Level and Facility Type, 1991

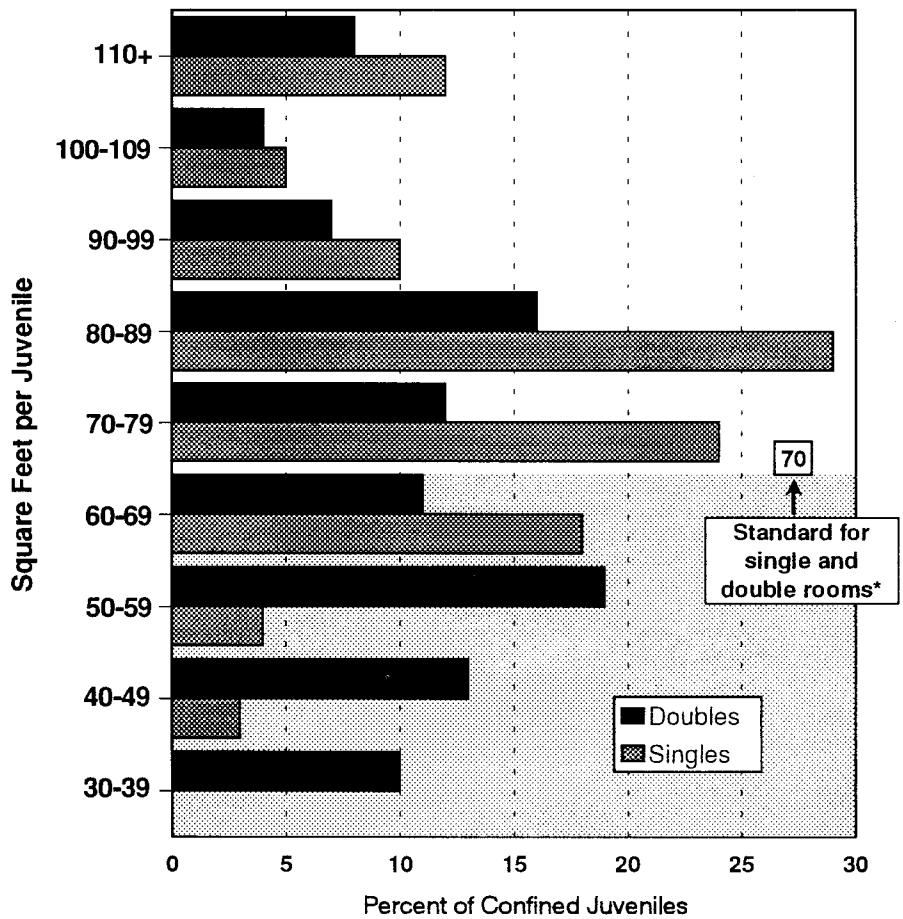
Occupancy Level of Sleeping Room	Detention Centers N=5,940	Reception Centers N=1,121	Training Schools N=11,724	Ranches N=1,493	Total N=20,278
1	57%	11%	24%	2%	31%
2	34%	70%	35%	44%	37%
3-4	3%	0%	3%	12%	4%
5-10	3%	0%	2%	10%	3%
11 plus	2%	19%	35%	32%	25%

Source: Mail Survey, 1991

Figures 4A–2 and 4A–3 show the percentage of juveniles in training schools who sleep in different sized rooms. Figures 4A–4 and 4A–5 present the same information for detention centers.

Figure 4A-2

Percent of Confined Juveniles in Single and Double Rooms by Average Square Feet per Juvenile in Training Schools



Source: Mail Survey, 1991

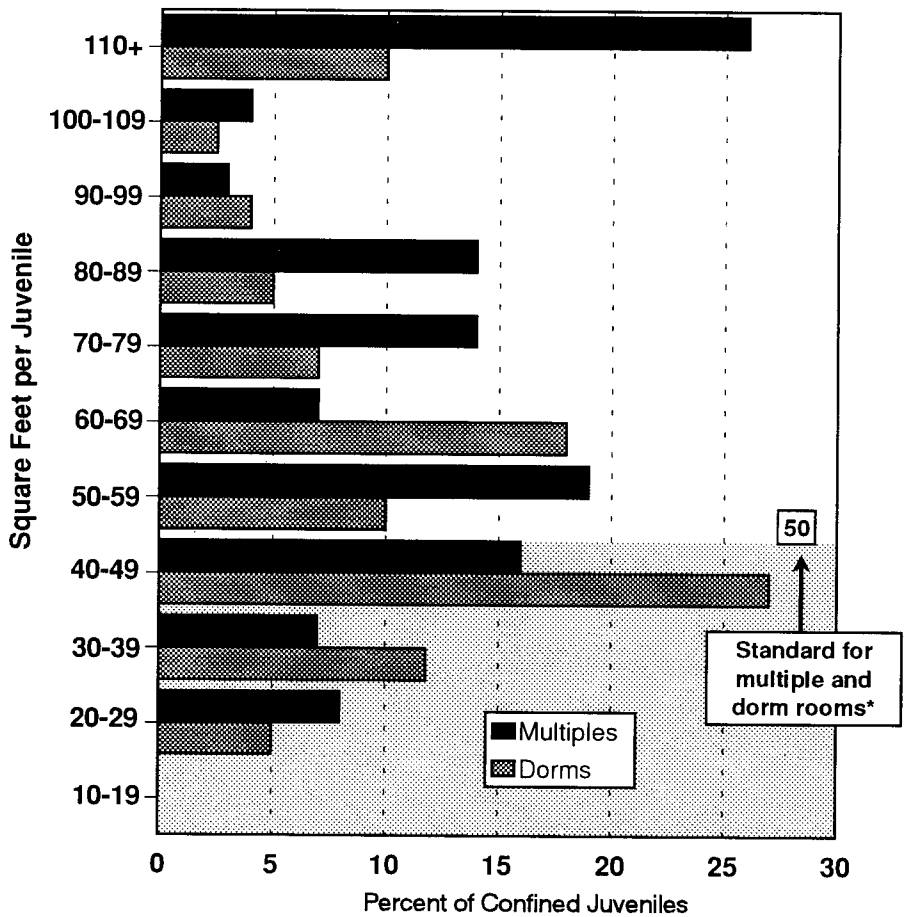
* Shaded area indicates single and double rooms that are not in conformance with requirements.

These figures show two patterns. First, there is wide variation in average room size. In training schools, for example, 5 percent of the juveniles who sleep in dorms are in rooms with less than 20 square feet per occupant, while 10 percent of those in dorms have more than 110 square feet per juvenile.

Second, almost all undersized double rooms in training schools and detention centers are large enough to meet the standard of 70 square feet if they house only one juvenile instead of two. It is likely that most of the undersized double rooms were originally intended for one person but were double-bunked in response to crowding.

Figure 4A-3

Percent of Confined Juveniles in Multiple Occupancy and Dormitory Rooms by Average Square Feet per Juvenile in Training Schools

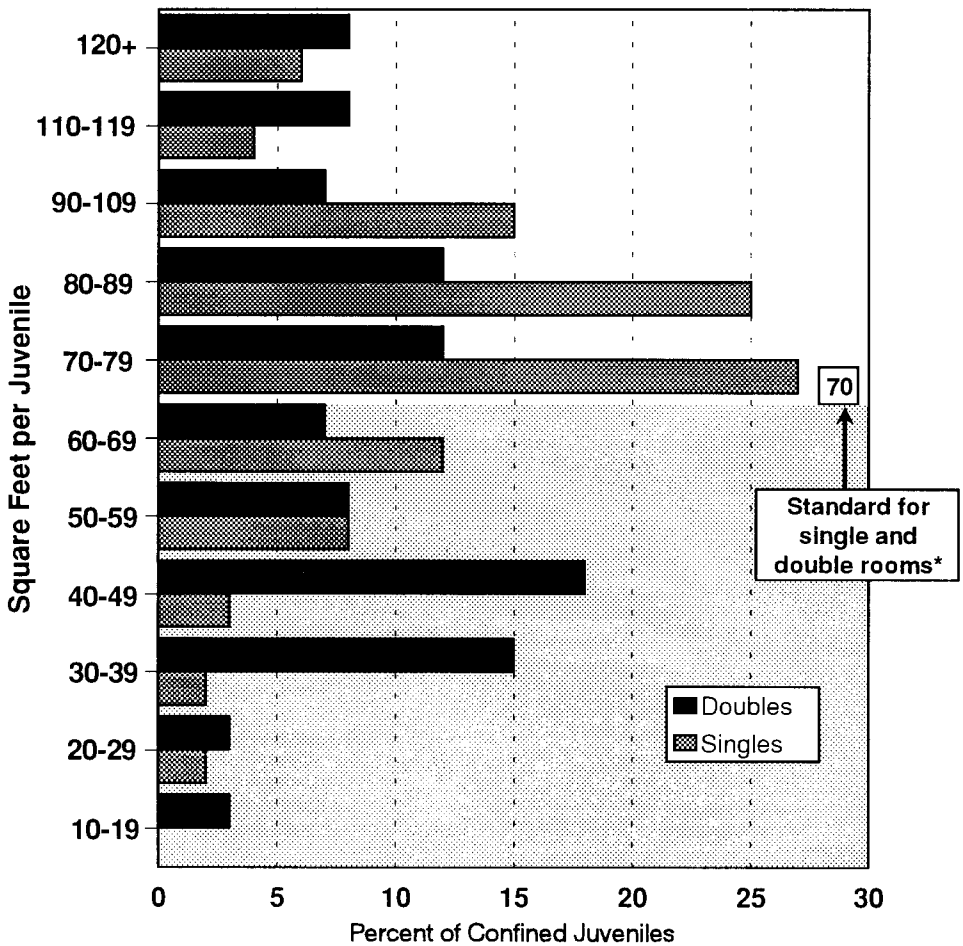


Source: Mail Survey, 1991

* Shaded area indicates multiple and dorm rooms that are not in conformance with requirements.

Figure 4A-4

Percent of Confined Juveniles in Single and Double Rooms by Average Square Feet per Juvenile in Detention Centers

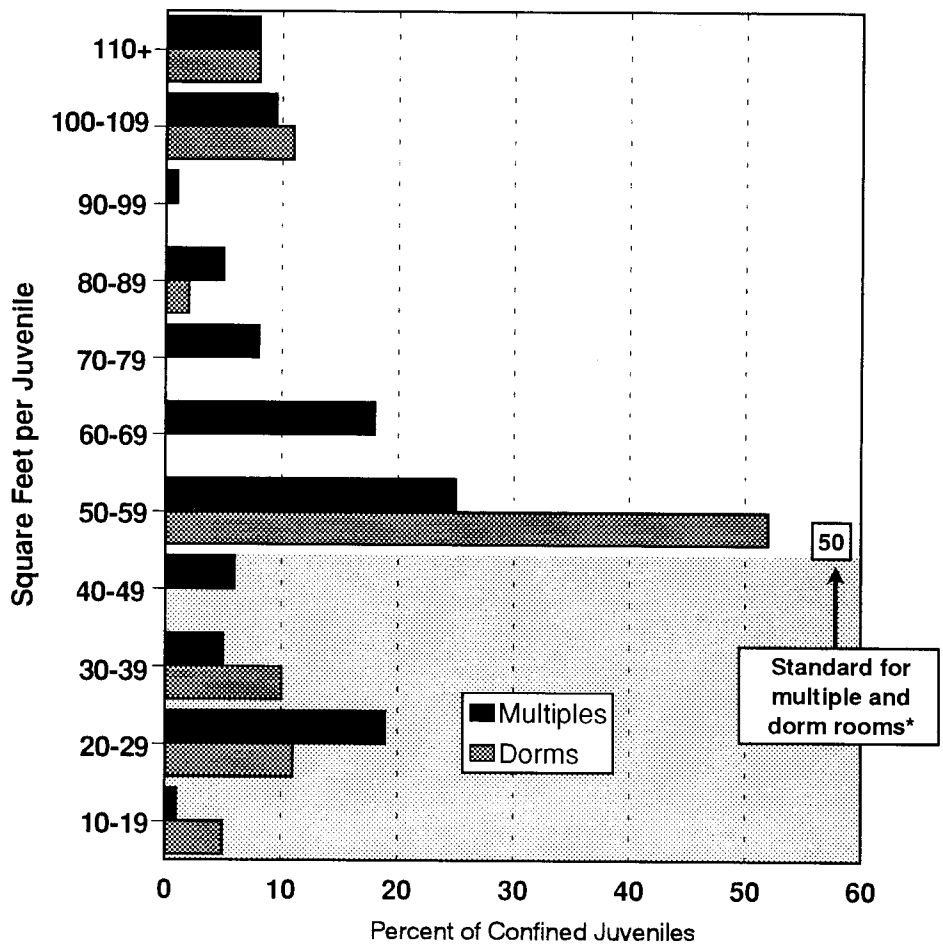


Source: Mail Survey, 1991

* Shaded area indicates single and double rooms that are not in conformance with requirements.

Figure 4A-5

Percent of Confined Juveniles in Multiple Occupancy and Dormitory Rooms by Average Square Feet per Juvenile in Detention Centers



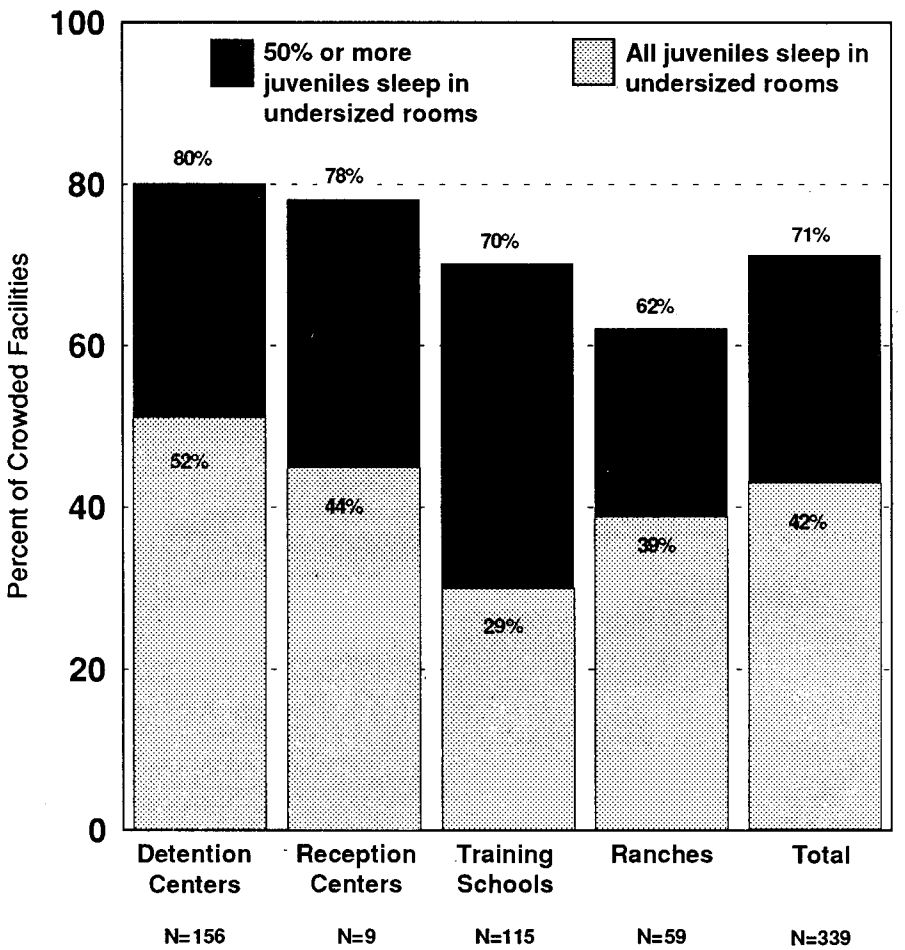
Source: Mail Survey, 1991

* Shaded area indicates multiple and dorm rooms that are not in conformance with requirements.

We also can look at crowding in sleeping rooms from the facilities' perspective. As shown in Figure 4A–6, in 71 percent of the crowded facilities at least one-half of the juveniles sleep in undersized rooms. In 42 percent of crowded facilities, all confined juveniles sleep in undersized rooms. Undersized sleeping rooms are apt to be a facility-wide problem. This may be because sleeping rooms throughout the facility were originally designed to be smaller than required by the criteria, or because of the substantial use of double-bunking in rooms intended for only one resident.

Figure 4A–6

Percent of Crowded Facilities in Which Half or More of Juveniles Sleep in Undersized Rooms



Source: Mail Survey, 1991

Except by removing walls between rooms, crowded single rooms cannot be made larger. Thus to eliminate undersized single rooms, those rooms must be closed or substantially renovated. For crowded multiple-occupancy rooms, however, the square feet per juvenile can be increased by reducing the number of juveniles who occupy the rooms. Most crowded double rooms could be converted into

single rooms that contain at least 70 square feet. Crowded triple rooms might be adequate in size for two occupants (i.e., 140 square feet), and certainly adequate for one. If we know the average square feet per juvenile in crowded sleeping rooms with different occupancy levels, we can estimate the number of juveniles who would have to be removed in order for those sleeping rooms to meet minimum size criteria.

Overall, it would be necessary to remove slightly more than 11,000 juveniles from confinement facilities, or about 18 percent of the confined population (Table 4A-4) to eliminate crowding in sleeping rooms. About 50 percent of those reductions (5,678 juveniles) would have to be made in training schools. This would involve closing all undersized single rooms, converting all crowded double rooms to singles, and reducing the numbers confined in rooms with three or more juveniles. To achieve these population reductions, admissions to detention centers would need to be lowered by 106,550, and admissions to training schools would need to be lowered by 9,200, assuming the average lengths of confinement remain at the 1991 level.

Table 4A-4

Number of Juveniles Who Would Need to be Removed to Eliminate Undersized Sleeping Rooms, by Facility Type, 1991

Current Occupancy Level	Detention Centers N=19,552	Reception Centers N=2,575	Training Schools N=33,688	Ranches N=6,387	Total N=62,203
One	3,393	134	2,992	107	6,626
Two	747	336	1,472	140	2,695
Three or four	65	0	75	103	243
Five to ten	104	0	84	42	230
Eleven or more	74	48	1,055	97	1,274
Total Reduction	4,383	518	5,678	489	11,068
Reduction as percent of population	22%	20%	17%	8%	18%

Source: Mail Survey, 1991

If officials decided to eliminate only undersized sleeping rooms housing 2 or more juveniles, it would be necessary to remove about 4,000 juveniles, or about 6.4 percent of those confined. Of these, about 60 percent would come from training schools.

Conversely, undersized sleeping rooms could be eliminated by expanding the supply of adequately sized sleeping rooms. Under this option, all undersized single rooms would have to be replaced with new single rooms that have at least 70 square feet and sufficient, adequately sized double- and multiple-occupancy rooms would need to be added. Altogether, about 11,000 beds would need to be provided

in new adequately sized sleeping rooms to eliminate crowding. In addition, in Chapter 5A we independently recommend eliminating all dormitories housing 11 or more residents. If that recommendation were to be implemented, an additional 11,100 beds in adequately sized sleeping rooms would need to be provided.

Inadequate sleeping rooms are more of a problem to the extent that juveniles spend considerable time in their sleeping rooms. The mail survey asked respondents to indicate how much time, on average, juveniles spend in their sleeping rooms per day. We asked this question for the facility population as a whole, not for juveniles in units with different sleeping room configurations. Table 4A-5 shows the results.

Table 4A-5

Percent of Juveniles by Average Amount of Time in Sleeping Rooms per Day, by Facility Type

Average Hours in Sleeping Room per Day	Detention Centers N=20,040	Reception Centers N=2,590	Training Schools N=35,037	Ranches N=7,083	Total N=64,751
Less than 10	35%	31%	46%	33%	40%
10 to 11	39%	4%	27%	29%	30%
11 to 12	7%	0%	9%	18%	9%
More than 12	19%	66%	18%	20%	21%

Source: Mail Survey, 1991

We would expect juveniles to spend 8 to 10 hours a day in their sleeping rooms simply to sleep. Given this, it appears that most juveniles in confinement spend relatively few waking hours in their sleeping rooms. Overall, 21 percent of confined juveniles spend more than 12 hours in their sleeping rooms each day, but 66 percent of juveniles in reception centers spend more than 12 hours per day in their sleeping rooms. Juveniles in training schools spend the least amount of time in their sleeping rooms—46 percent spend less than 10 hours per day in their rooms. We checked the relationship between conformance to the criteria on average square feet per juvenile in sleeping rooms and average time spent in sleeping rooms and found that juveniles spend more time in sleeping rooms that are crowded than in those that are not crowded. However, the difference—while significant at the 0.05 level—was only about 20 minutes per day.

In summary, almost one-third of juveniles sleep in rooms which, on average, are crowded, and about one-third of all facilities house some juveniles in crowded sleeping rooms. In facilities with crowded sleeping rooms, a substantial percentage of the population sleep in crowded rooms. On average, uncrowded sleeping rooms typically exceed minimum square footage requirements by a substantial margin. Similarly, crowded sleeping rooms fall below minimum space requirements by a substantial margin. To eliminate crowded sleeping rooms, it would be necessary to remove about 11,000 juveniles from confinement facilities, about 18 percent of the confined population, or to provide about 11,000 new beds in adequately sized sleeping rooms.

Size of Living Unit

Living units are a second, and intermediate, level at which the adequacy of living space is assessed. Living units are self-contained sections of facilities where a subgroup of juveniles live, sleep, and attend to hygiene needs.

Among nonconforming facilities, the size of the largest living units varies considerably. Overall, 10 percent of facilities have 36 or more residents in their largest living units, 4 percent have 48 or more, and 1 percent have 100 or more. Nonconforming detention centers have fewer residents in their largest living units—just 5 percent of the facilities have 36 or more residents, and only 2 facilities have more than 60 residents in their largest units. In training schools, 15 percent of the facilities have 36 or more residents in their largest living units, while only 1 percent of the facilities have 80 or more residents in their largest units. Fifteen percent of ranches have 36 or more residents in their largest living units, and 5 percent have 100 or more juveniles in their largest living units (data not shown).

While mail survey data provide information on the largest, smallest, and average living unit sizes, the variation in living unit sizes is too great to allow us to determine the percentage of juveniles in large living units. Nineteen percent of juveniles are in facilities where the smallest living unit has more than 25 residents, while 51 percent are in facilities where the largest living unit has more than 25 residents. We did, however, collect data on the population of every living unit at the 95 facilities visited. Based on these data, we estimate that slightly over one-third of confined juveniles are housed in living units with more than 25 residents (Table 4A–6). About 13 percent are in living units with more than 50 residents.

Table 4A–6

Estimated Percent of Confined Juveniles by Size of Living Units

Number of Juveniles in Living Unit	Estimated Percent of Juveniles	95% Confidence Interval
10 or fewer	13%	±5.9%
11 to 25	51%	±8.6%
26 to 49	23%	±7.0%
50–99	10%	±5.3%
100 or more	3%	±3.3%

Source: Site Visit Protocol, 1991

In most of the sites we visited, large living units were the result of facility crowding; that is, the living units originally were designed to house 20 or 30 juveniles but housed 50 to 60 due to crowding. The effects of such crowding were not limited just to sleeping areas, although those effects were

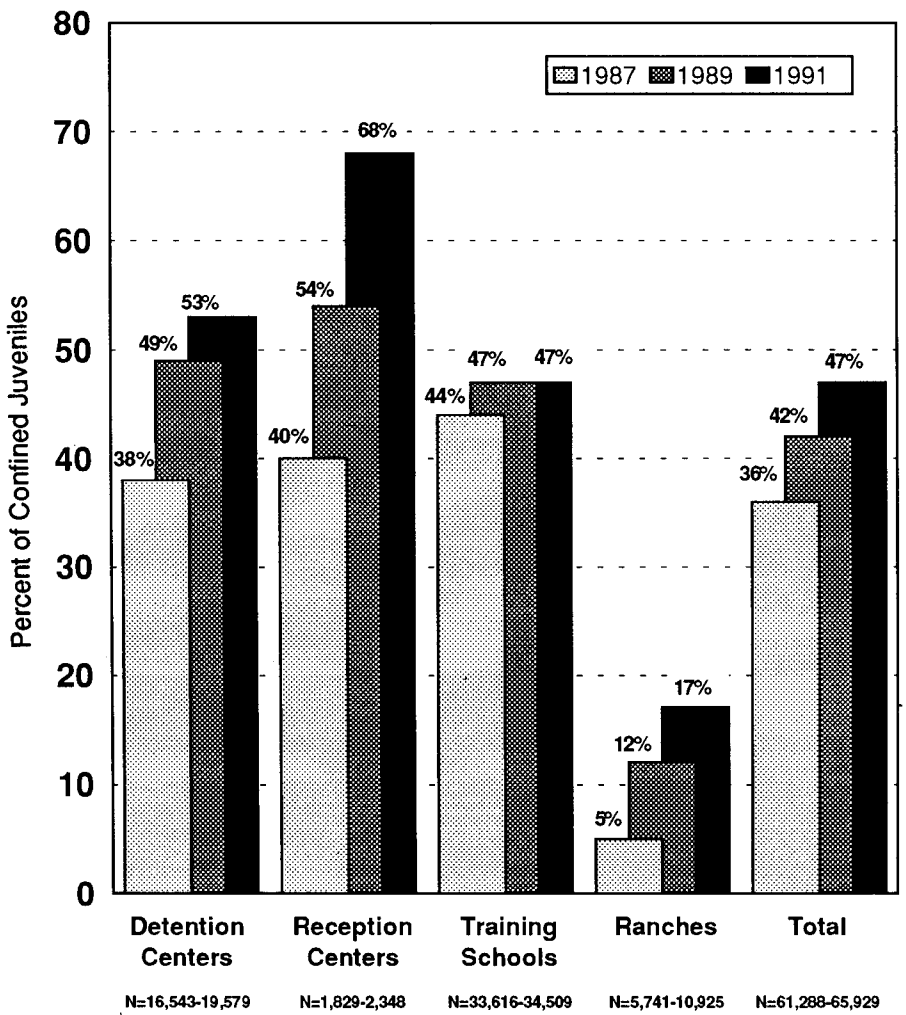
severe.[17] All common-use areas—showers, bathrooms, day rooms, recreation rooms, etc.—were used more heavily and suffered greater wear in the more crowded living units. In crowded locked living units, juveniles quite literally ran into each other in common-use areas.

Population as a Percent of Reported Design Capacity

Facility capacity is the third and broadest level at which we assessed the adequacy of living space. Between 1987 and 1991, more facilities became more crowded, as measured by changes in population as a percent of reported design capacity (Figure 4A–7). Overall in 1987, 36 percent of juveniles were

Figure 4A–7

Percent of Confined Juveniles in Facilities Whose Average Daily Population Exceeds Reported Design Capacity by Facility Type, 1987–1991



Sources: CIC Censuses, 1987, 1989, 1991

[17] In one large crowded dormitory we inspected, juveniles had just 22 square feet of floor space each. In the mail survey, one facility reported juveniles had less than 20 square feet of floor space each in large dormitories. By comparison, an average size single bed takes up almost 21 square feet of floor space.

housed in facilities whose population was larger than their design capacity. That figure had increased to 47 percent only 4 years later.

Reception centers had the biggest increase in proportion with populations above reported design capacity, followed by detention centers and ranches. The proportion of training schools rose between 1987 and 1989 but stayed the same in 1991.

Crowding levels vary substantially by types of facilities (Table 4A-7).

Table 4A-7

Percent of Juveniles: Distribution of Population as Percent of Reported Design Capacity, by Facility Type

	Detention Centers N=19,579	Reception Centers N=2,348	Training Schools N=33,616	Ranches N=5,741	Total N=61,284
<=80%	17%	2%	11%	16%	13%
81-90%	12%	0%	15%	33%	15%
91-100%	18%	30%	27%	34%	25%
101-110%	17%	36%	17%	6%	16%
111-120%	13%	0%	6%	7%	12%
121-130%	10%	30%	13%	4%	12%
Over 130%	13%	2%	11%	0%	8%

Source: CIC Census, 1991

Across all facilities, nearly one out of three confined juveniles are in facilities with more than 120 percent of design capacity. Nearly half (46 percent) of the confined juvenile population resides in facilities in which the population exceeds the reported design capacity. By this measure, crowding appears most extensive in reception centers, where 68 percent of juveniles are in facilities in which populations exceed reported design capacity. The highest proportions of juveniles living in facilities where the population exceeds the reported design capacity by more than 130 percent are detention centers and training schools at 13 percent and 11 percent, respectively.

Across all facilities, the total population is 96.7 percent of reported design capacity, up from 91.2 percent in 1987. Although total population remains below total capacity, two factors must be considered. First, as noted above, many practitioners argue that facilities function less effectively when the population exceeds 80 to 90 percent of capacity. Second, excess capacity is typically inaccessible to facilities that are crowded. Crowded training schools, for example, cannot use the excess capacity that might be available in detention centers. Crowded detention centers in one State cannot use excess detention capacity in another State. Although uncrowded detention centers within a State may cooperate by holding

detained juveniles for counties whose detention centers are crowded, that practice imposes added costs on the system—for instance, travel and personnel time—and impairs juveniles' access to families and attorneys. Even within a network of State-run training schools, excess capacity in some facilities may not be available to ease crowding elsewhere because the uncrowded facilities may not provide the correct security level, may not admit males (or females), or may admit only juveniles in a certain age range or with special needs.

Among those facilities whose populations were over their reported design capacity, the average population was 120.3 percent of design capacity (data not shown). Despite the increase in the incidence of overpopulated facilities from 1987 to 1991, the average ratio of population to capacity in these facilities did not increase. This suggests that at some point administrators are either able to resist further additions to already crowded facilities, are simply unable to accommodate them, or that juvenile justice systems have altered practices to prevent crowding levels from increasing.

Table 4A–8 shows the reductions in population that would be needed to bring populations into line with reported design capacity. Overall, juvenile facilities would need to house 4,849 fewer juveniles to make their populations equal reported design capacity and would need to house 8,524 fewer juveniles to bring their populations to 90 percent of design capacity. Assuming average durations of confinement are constant at 1991 levels, these population reductions would require admissions to detention centers to be cut by 46,400 in order to lower populations to no more than 100 percent of design capacity and by 72,700 in order to lower populations to no more than 90 percent of design capacity. Admissions to training schools would need to be reduced by 4,260 in order to lower populations to no more than 100 percent of design capacity and by 7,650 in order to lower populations to no more than 90 percent of design capacity.

Conversely, facilities could be expanded to eliminate crowding. Juvenile facilities would need to increase capacity by 4,850 to eliminate crowding and increase capacity by 8,525 to bring populations to 90 percent of capacity. It is important to emphasize that capacity expansion involves more than just adding sleeping rooms. Common-use areas, program and support space, and services (heating, plumbing, etc.) also would need to be expanded, and additional staff would have to be provided.

Earlier, we noted that slightly more than 11,000 juveniles would need to be removed from juvenile facilities to eliminate undersized sleeping rooms. If that were done, it would still leave about 2,650 juveniles in facilities with populations exceeding their design capacity.

Table 4A-8

Reductions Needed To Bring Population to 100% and 90% of Reported Design Capacity, by Facility Type, 1991

Population reduction needed to achieve:	Detention Centers N=19,579	Reception Centers N=2,348	Training Schools N=33,616	Ranches N=5,741	Total N=61,284
100% of design capacity	1,907	195	2,627	119	4,849
90% of reported design capacity	2,986	348	4,715	475	8,524

Source: CIC and Mail Survey, 1991

Facility Responses to Crowding

During site visits, we asked facility administrators if they had experienced problems with crowding and to describe their primary responses to crowding. Administrators at 65 percent (± 10 percent) of the 95 facilities indicated their facilities had experienced crowding. Based on their responses, we estimate that 31 percent (±10 percent) of confined juveniles are in facilities that have increased releases to cope with crowding, 19 percent (±9 percent) are in facilities that have used intake control to limit crowding, 18 percent (±9 percent) are in facilities that have a "cap" on facility population (implemented either by courts or agency policy), and 17 percent (±8 percent) have used other approaches as their primary response to crowding (Table 4A-9).

Although the site visit data cannot support distinctions by facility type, anecdotal evidence suggests that detention centers most often rely on intake control or screening, training schools rely most often on releasing, and ranches rely most often on caps or intake control.[18]

We asked administrators to rate the effectiveness of each of the responses to crowding that they had used at their facility. They used a 4-point scale, where 1= "excellent," 2= "good," 3= "fair," and 4= "poor." Table 4A-10 shows their ratings of effectiveness for individual responses they have used.

[18] Because many ranches are private facilities, they are able to establish strict limits on capacity and stop accepting new admissions when those limits are reached.

Table 4A-9

Percent of Juveniles in Facilities Using Different Primary Responses To Control Crowding, 1991

Primary Response To Control Crowding	% Juveniles in Facilities Using This Primary Response	95% Confidence Interval
Increase releases	31%	±10%
Intake control or screening	19%	±9%
"Cap" on population	18%	±9%
Alternatives to confinement	8%	±6%
Transfers	6%	±5%
Other	17%	±8%

Source: Site Visit Protocol, 1991

Table 4A-10

Administrators' Ratings of Specific Responses To Reduce Crowding, 1991

Response To Reduce Crowding	Average Rating	95% Confidence Interval
Transfer to other facilities	2.5	±.9
Accelerate release	2.1	±.4
Alternatives to confinement	2.0	±.9
Population Cap	1.3	±.3
Intake control	1.2	±.2

Source: Site Visit Protocol, 1991

Rating Scale: 1= "excellent," 2= "good," 3= "fair," and 4= "poor."

Administrators rated limits on admissions through intake control and population caps as the most effective responses to crowding, with average ratings just below the "excellent" level. Accelerated releases and alternatives to confinement had average ratings of "good." Transfers to other facilities had an average rating between "good" and "fair."

Table 4A-11 shows administrators' assessment of the overall effectiveness of the responses they used in controlling crowding at their facilities.

Table 4A-11

Administrators' Assessments of Effectiveness of Responses in Controlling Crowding

Rating—Overall Effectiveness of Responses in Controlling Crowding	Percent Giving This Rating	95% Confidence Interval
Excellent	47%	±11%
Good	33%	±10%
Fair	11%	±7%
Poor	9%	±6%

Source: Site Visit Protocol, 1991

Almost one-half of administrators rated the effectiveness of their responses as excellent. Those responses, by and large, have relied on minor or temporary adjustments to the number of juveniles admitted to confinement or to the duration of confinement. It is by no means clear that these responses will be effective if crowding increases or becomes more persistent.

Moreover, available responses to crowding are not without costs. For example, when crowded detention centers send juveniles to another detention center 200 miles away, taxpayers must pay added transportation and personnel costs, and juveniles' contacts with family and counsel are diminished. Limiting intake in training schools may cause populations to balloon in detention or reception centers. Shortening durations of confinement in training schools may prevent treatment plans from being fully implemented.

Summary Regarding Living Space

Thirty-seven percent of all facilities hold juveniles in sleeping rooms that are, on average, smaller than required by nationally recognized standards. This results in one-third of confined juveniles sleeping in rooms that, on average, are crowded, given square footage requirements specified in the assessment criteria. These facilities often hold large proportions of their populations in crowded sleeping rooms. Seventy-one percent of crowded facilities have one-half or more of their population in rooms that are, on average, crowded, and 42 percent of crowded facilities have 100 percent of their population in rooms that are, on average, crowded. About 25 percent of juveniles confined in undersized sleeping rooms are in dormitories housing 11 or more residents. As we shall see in Chapter 8, both dormitory housing and crowded conditions are associated with increased threats to juveniles' safety.

Fifty-one percent of confined juveniles are in 22 percent of the facilities whose largest living units exceed 25 juveniles. The largest nonconforming living units are in ranches and training schools. Overall, we estimate that 36 percent of juveniles are in living units that house more than 25 persons.

Approximately 46 percent of juveniles are confined in facilities whose populations exceed reported design capacity, up from 36 percent in 1987. By this measure, crowding is most severe in reception centers, where 68 percent of juveniles are held in facilities whose populations exceed reported design capacity. The average crowded facility had a population that was 120.3 percent of its reported design capacity, about the same as in 1987.

Recommendations Regarding Living Space

Our analysis—described more fully in Chapter 8—found a positive relationship between crowded conditions and injuries inflicted by juveniles on staff. These findings are consistent with the adverse effects of crowding reported in the large body of research on adult prisons. Further, crowding seems likely to have other adverse effects as well. In detention centers, facilities that were over their design capacity had higher rates of suicidal behavior and short-term confinement. In training schools, being over design capacity was associated with higher rates of attempted escape.

Facilities may cope with crowding in a number of ways. Some facilities reported that they reduce crowding by early release, and indeed the most recent CIC census data indicate that overall lengths of stay in all institutions fell by 15 percent between 1986 and 1990. But such early release can short circuit treatment programs, defeating the original commitment decision. Other facilities, especially training schools and ranches, reported that they simply refuse admissions. But this can induce both crowding and longer stays in detention and reception centers—which are often not equipped to offer the educational and other program services appropriate for long-term confinements.

Crowding can be alleviated by reducing the number of confined juveniles or by expanding the supply of confinement beds. To eliminate crowded sleeping rooms without new construction or renovation, all undersized single rooms would need to be closed. Most crowded double rooms could be retained for single occupants, though some would have to be closed, since they are inadequate even for single occupancy. Other crowded multiple-occupancy rooms could be retained with fewer occupants. Altogether, to eliminate all crowded rooms, about 11,000 residents would need to be removed from juvenile facilities, or 18 percent of the confined population. Conversely, about 11,000 new beds would need to be added in adequately sized sleeping rooms.

The factors that drive crowding in juvenile facilities lie mostly outside the control of those facilities. Facilities may be able in some cases to resist pressure for admissions or to offset admission through early releases, but the numbers of admissions reflect decisions by police, prosecutors, and courts made in the context of available community alternatives such as shelters, probation, and halfway houses. Decisions involving construction of new confinement facilities, expansion of alternative facilities, or review of commitment policies need to be undertaken collaboratively.

We do not categorically oppose construction of new juvenile facilities. New construction may be necessary to replace existing seriously substandard facilities, or to expand capacity in some areas. However, capacity expansion merely responds to, but does not alter, factors that drive juvenile confinement levels. It does not establish clear priorities for the use of confinement or for the expenditure of public funds among competing social needs. Without coordinated policies, there is no guarantee that additional facilities will not rapidly be filled to or beyond capacity.

Officials also can respond to crowding by altering the flow of confined juveniles. Ultimately, these responses either cut admissions or shorten durations of confinement. For example, expanded use of intake control in detention may screen out more juveniles who do not require secure confinement or whose immediate needs require some other placement (for example, a shelter or a detoxification center).

Improved classification might result in more reliable identification of juveniles who could be safely released to community placements. Better classification also might prevent some youth from being placed in higher security classifications than required and, hence, accelerate their eligibility for release. Improved information flow between facilities and juvenile probation and parole services might cut the time required to complete assessments or prepare reentry plans.

Efforts to alter the flow of confined juveniles, however, usually require expanded placement resources. Intake control is less effective in detention if community placement options like emergency foster homes or shelter care are not available. The best and most rational classification systems are impaired if there are not enough community residential and nonresidential placement options for low-risk offenders or if the choice of institutional placements is determined by where beds are vacant rather than by juveniles' risks and needs. As institutional crowding levels increase, competition for limited funding grows, making it more difficult to establish an adequate range of community placement options.

Finally, the decisions involving confinement capacity, alternative capacity, and commitment policies need to be coordinated. The forces that drive crowding are systemic. The effects of crowding also are systemic. To date, however, most responses to crowding have been tactical; officials make minor adjustments in response to the symptoms of crowding but leave its causes untouched.

We recommend that States implement an ongoing planning process that identifies decisions that affect use and duration of juvenile confinement, identifies characteristics of juvenile offenders processed through the system, and documents the capacities of available confinement and nonconfinement placement options. States should use this information to establish and review policies that regulate the use and duration of confinement and to govern future provision of juvenile placement options.

Organizations that have developed nationally recognized standards give preference to housing juveniles in single rooms or small multiple-occupancy rooms. We found that the percentage of juveniles in dormitories is positively associated with juvenile-on-juvenile injury and the use of short-term confinement. Juveniles in dormitories injure other juveniles more often, and staff in facilities with dormitories more frequently rely on short-term isolation to control juvenile behavior. The finding with respect to juvenile-on-juvenile injury is consistent with prior research that shows that increased social density has more negative effects on juveniles' behavior than reduced space does.

We recommend that juvenile facilities built in the future not house residents in dormitories. In existing facilities, dormitories housing 11 or more juveniles should be phased out at the earliest possible time.

We recommend that OJJDP support controlled research to study the effects of crowding on juvenile and staff behavior and on outcomes in detention and corrections facilities.

B. Health Services

Section B describes medical services in juvenile confinement facilities.[19] The literature on conditions of confinement calls for health screening and continued access to health care throughout a

[19] Mental health services are considered in Section 6C.

juvenile's stay.[20] Six assessment criteria are used: providing an initial health screening, performing health assessments, explaining to juveniles how they obtain access to health services, holding frequent sick calls, having written arrangements for emergency medical care, and having staff trained in first aid and cardiopulmonary resuscitation (CPR). This section describes the content of health screenings and health appraisals and describes who performs screenings. It shows how frequently medical staff are available to confined juveniles and describes medical staff ratios. Finally, it describes rates of emergency medical care incidents during the last year in each type of facility.

Assessment Criteria

a) Initial Health Screening

Initial health screening is a quick assessment of a juvenile's physical condition conducted at admission, often by nonmedical staff. Swift initial health screening is important to determine whether juveniles have injuries or illness requiring immediate medical attention. Juveniles arriving at detention centers are particularly in need of this attention because they may have recently consumed alcohol or drugs or may have been injured. We assessed conformance based on whether or not facilities complete an initial health screening within 1 hour of admission.

b) Health Appraisals

Appraisal is the next step following screening. A thorough health appraisal may detect less obvious health problems that were overlooked in the screening. Equally important, a health appraisal establishes a medical record for each juvenile that may be referred to if future health problems develop. We assessed health appraisals based on whether or not facilities performed a complete health appraisal for juveniles confined for more than 7 days.

c) Access to Information on Medical Services

The provision of basic medical services includes access to information on medical services. For health problems that arise during a juvenile's stay in the facility, residents need to know that medical services are available and how to obtain them in order to secure proper and prompt treatment. Facilities can ensure that juveniles have this information by including medical services among the topics covered during the juveniles' orientation to the facility. We assessed facilities on their provision of information on access to medical services during orientation.

d) Sick Call

Facilities can also provide juveniles with access to medical services by establishing specific times, usually referred to as sick call, when juveniles may bring their medical problems to the attention of a health care professional. Sick call allows juveniles to communicate directly with health care staff rather than through direct care staff. One large facility that we visited had a nurse stationed in the cafeteria during lunch so that as each living unit waited in line to get food, the juveniles could speak with the

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[20] Litigation against juvenile institutions in the lower Federal courts has established more specific minimum standards of care. These standards pertain to the adequacy of medical screening upon admission, the adequacy of medical services, the adequacy of psychological screening upon admission, the adequacy of available psychological services, the administration of prescription medications or other psychotropic drugs, and the right of juveniles to refuse treatment (Soler, p. 2-14).

nurse. We assessed ongoing provision of routine health care based on whether or not facilities had appropriate numbers of sick calls per week.

e) Written Arrangements for Emergency Medical Care

We assessed access to emergency services in terms of the existence of a written arrangement for emergency health care. In addition to onsite provision of medical services, facilities must sometimes provide emergency care for serious injuries and illnesses. Access to emergency medical services includes written arrangements for providing emergency medical services and staff training in first aid and cardiopulmonary resuscitation. A written arrangement between a juvenile facility and a medical institution makes clear that the medical institution is willing to accept confined juveniles, who may pose challenges to hospital staff given the need for close surveillance while the juvenile is outside the facility.

f) Staff Training in First Aid and CPR

Because youth supervision staff spend their day in close proximity to confined juveniles they are the first to know when a resident has been injured or become ill. As a result, in addition to alerting onsite medical staff or emergency medical services of a juvenile's condition, these staff may need to provide first aid or CPR until medically trained personnel arrive. We assessed facilities on whether or not staff receive training in first aid and CPR.

Table 4B–1 presents the percentage of juveniles in facilities that meet each of the six assessment criteria. Most facilities meet some of the assessment criteria, but only one-fourth of juveniles are held in facilities that meet all six, and 7 percent are held in facilities that meet one-half or fewer of the criteria.

The most obvious weakness is in routine screening. As we shall see, the problems with routine screening are largely a matter of delayed screening rather than no screening. In addition, some of the screening in detention centers is often done by untrained staff. Basic services are especially weak in ranches. Although access to emergency care appears to be especially weak in reception centers, there may be more reason to be concerned about ranches in this regard. The rest of Section B reviews each of the six areas in detail.

Initial Health Screening

Health screening provides a rough sense of a juvenile's physical well-being at the time of admission. During the screening, a staff member interviews and observes juveniles to determine if they require immediate medical attention. The ACA recommends that each individual be screened by medically trained personnel immediately after arrival at the facility. A facility meets this assessment criteria if a medically trained staff member performs a health screening within 1 hour of arrival.[21]

Screening is usually conducted by using a checklist that prompts the staff member to ask the juvenile some medical questions, assess the juvenile's mental state, and check for injuries and intoxication. The quality and comprehensiveness of the screening depends on the specificity and completeness of the checklist and on the medical knowledge of the staff member conducting the screening. Within large facilities with 24-hour medical staffing, a nurse typically conducts the screening. Smaller facilities are more likely to rely on a youth supervision staff member who has received some medical instruction.

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[21] The ACA standard requires health screenings to be performed immediately for every juvenile admitted to any facility, including those transferred directly from other facilities.

Table 4B-1

Percent of Juveniles in Facilities That Meet Health Assessment Criteria in Each of Three Areas and in All Areas by Facility Type

	Detention Centers N=18,371 -20,047	Reception Centers N=2,327 -2,618	Training Schools N=30,265 -34,960	Ranches N=6,061 -7,046	Total N=57,025 -64,672
Routine screening[a]	**79%**	**82%**	**44%**	**54%**	**58%**
Health appraisals[b]	**80%**	**93%**	**82%**	**66%**	**80%**
Explaining access to services[c]	**90%**	**98%**	**95%**	**81%**	**92%**
Sick call[d]	**92%**	**94%**	**94%**	**60%**	**90%**
Written arrangements for emergency care[e]	**94%**	**70%**	**89%**	**92%**	**90%**
Staff training in first aid and CPR[f]	**92%**	**99%**	**84%**	**90%**	**88%**
Percent of juveniles in facilities that conform to all criteria	48%	48%	16%	4%	26%
Conform to five criteria	36%	46%	47%	54%	44%
Conform to four criteria	13%	2%	32%	15%	23%
Conform to fewer than four criteria	3%	4%	6%	28%	7%

Source: Mail Survey, 1991

[a] For information on percent of facilities that conform, see Appendix E, Table E-4.
[b] For information on percent of facilities that conform, see Appendix E, Table E-5.
[c] For information on percent of facilities that conform, see Appendix E, Table E-6.
[d] For information on percent of facilities that conform, see Appendix E, Table E-7.
[e] For information on percent of facilities that conform, see Appendix E, Table E-8.
[f] For information on percent of facilities that conform, see Appendix E, Table E-9.

As shown in Table 4B–1, 58 percent of juveniles are held in facilities that perform health screening within 1 hour of admission.[22] Seventy-nine percent of juveniles held in detention centers are screened within 1 hour of admission. Screenings are least common for juveniles in training schools and ranches.

Virtually all juveniles in detention centers and reception centers, and 9 out of 10 in training schools, get health screenings at some point. Most nonconformance in detention and reception centers is due to timing—health screenings are performed, but not completed within 1 hour (Table 4B–2). The same pattern is evident in training schools, but the timing problem is worse—47 percent of juveniles are in training schools that perform health screenings, but do not complete them within 1 hour. Ranches have a distinctly different pattern of nonconformance: 25 percent of juveniles do not get health screenings at all, while another 20 percent get them, but not within 1 hour. Ranches also are most likely to rely on health screenings completed at other facilities. Indeed, only 12 percent of juveniles confined in ranches are in facilities that conduct their own health screening and complete them within 1 hour.

Table 4B–2

Percent of Juveniles Receiving Initial Health Screening, by Timing and Facility Type, 1991

	Detention Centers N=20,022	Reception Centers N=2,618	Training Schools N=35,070	Ranches N=6,983	Total N=64,693
Health screening performed	98%	98%	91%	75%	92%
At another facility	0%	5%	18%	43%	15%
At this facility					
Within 1 hr[a]	79%	77%	26%	12%	43%
1 to 3 hrs	12%	15%	21%	9%	16%
3 plus hrs.	7%	1%	26%	11%	18%

Source: Mail Survey, 1991

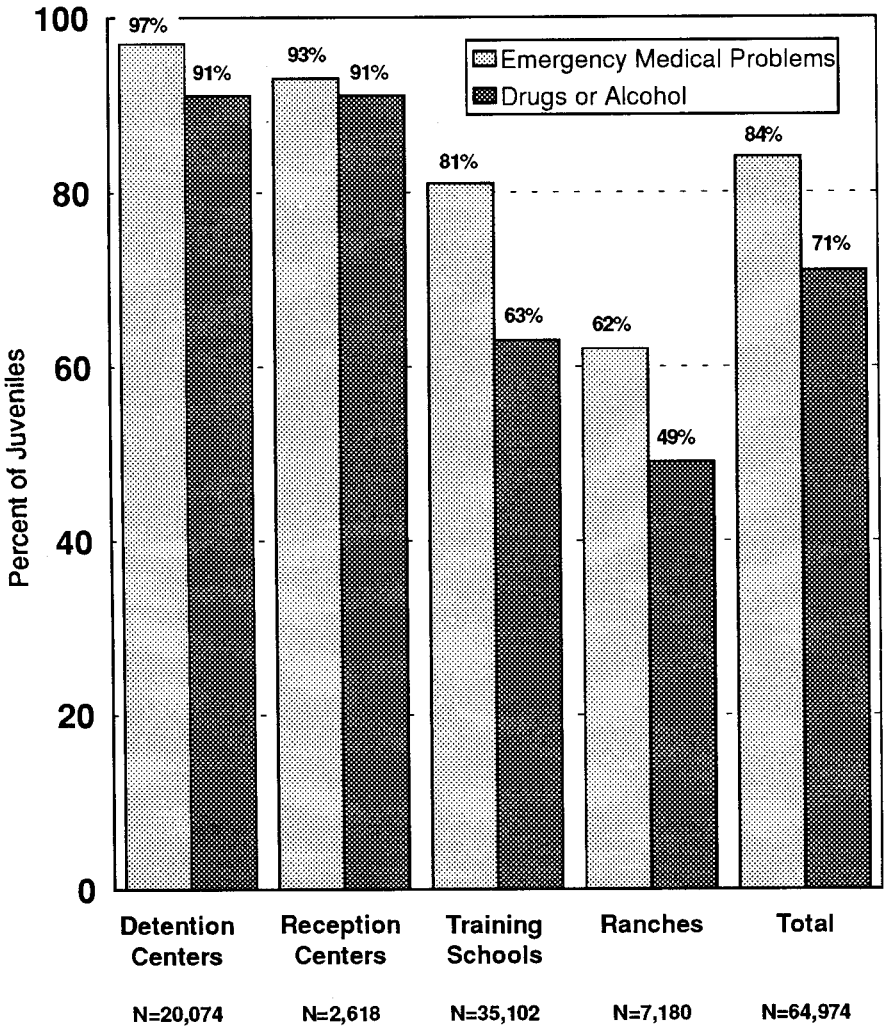
[a] This line shows the percent of juveniles who are in facilities that conform to the ACA standard on health screening.

[22] Health screenings and appraisals are conducted on admission to the facility. We considered screenings and appraisals based on the population of facilities rather than admissions so that we could compare them to other health services criteria. It is important to note, however, that detention centers conduct a disproportionate number of screenings and appraisals because they admit over 500,000 juveniles per year. Therefore, the burden on the staff and resources of detention centers is greater than for facilities where the turnover rate of residents is lower.

We collected some information on the content of health screenings in the mail survey and more detailed information during site visits. The mail survey indicates that approximately 84 percent of juveniles are screened for emergency medical problems and 71 percent for drug or alcohol use (Figure 4B–1).[23] Juveniles held in detention and reception centers are more likely to be screened for these conditions than are juveniles held in training schools or ranches.

Figure 4B–1

Percent of Juveniles in Facilities That Perform Health Screening for Emergency Medical Problems and Drugs or Alcohol by Facility Type



Source: Mail Survey, 1991

[23] This percentage includes juveniles held in facilities that conduct screenings but do not meet the assessment criterion of conducting screenings within 1 hour of admissions.

Site visitors collected copies of facilities' health screening forms during the site visits, allowing them to note what types of observations are made during health screenings and what types of questions juveniles are asked. The most common observations are the behavior of juveniles, such as their consciousness or conduct, and the condition of their skin (Table 4B-3).

Table 4B–3

Observations Recorded on Health Screening Form, by Percent of Juveniles and Facility Type

Observations of:	% of Juveniles
Behavior (consciousness, conduct, etc.)	62% ± 10%
Deformities	58% ± 10%
Ease of movement	41% ± 10%
Skin condition	80% ± 8%

Source: Site Visit Protocol, 1991

The most common questions asked of juveniles during health screenings are whether they are currently ill, whether they have dental problems, and whether they have mental health problems (Table 4B-4).

Table 4B–4

Questions Recorded on Health Screening Form, by Percent of Juveniles and Facility Type

Questions about:	% of Juveniles
Current illness	94% ± 5%
Dental problems	74% ± 9%
Mental health problems	73% ± 9%
Prior mental health treatment or hospitalization	57% ± 10%
Pregnancy[24]	75% ± 13%

Source: Site Visit Protocol, 1991

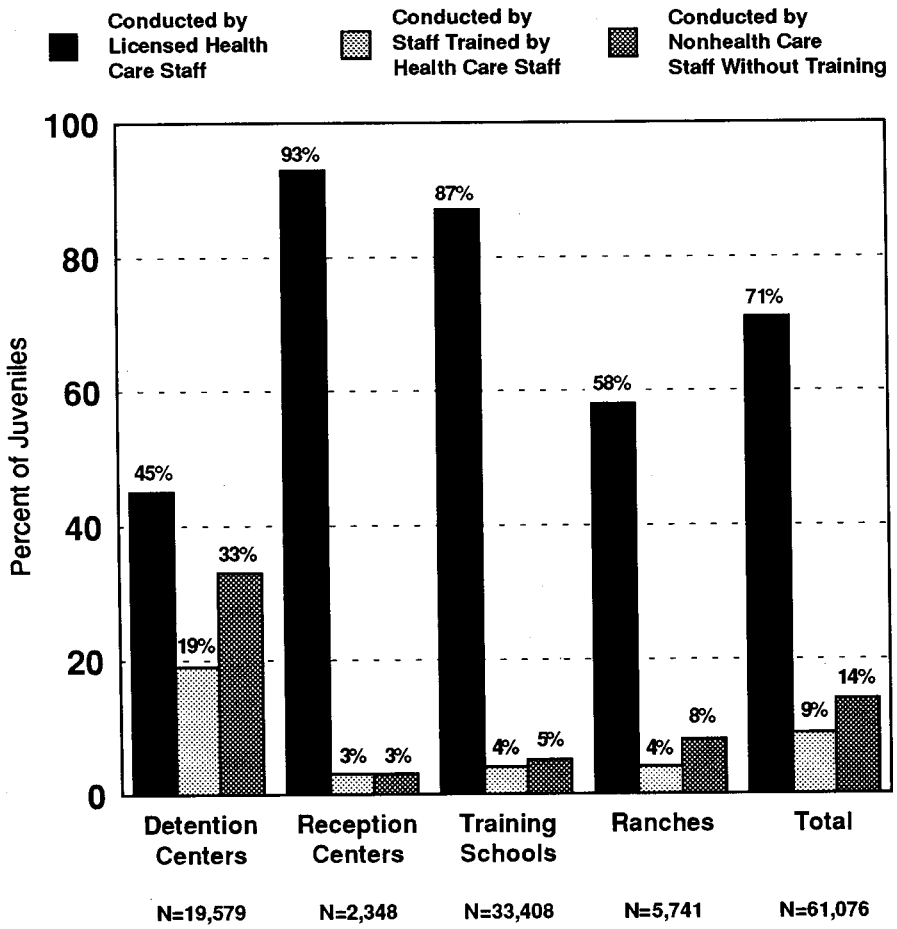
A majority of juveniles are held in facilities where health care staff conduct the health screenings. Those facilities that use other staff members to conduct health screenings do not tend to provide training, however. While detention centers are more likely than training schools or ranches to conduct screenings,

[24] Includes only facilities that hold females.

33 percent of juveniles in detention centers are held in facilities where screenings are conducted by staff who have not been trained by medical personnel (Figure 4B-2).

Figure 4B–2

Percent of Juveniles Receiving Health Screening
by Staff Responsible and Facility Type



Source: CIC Census, 1991

Health Appraisals

The health appraisal consists of a more thorough examination than a medical screening. Appraisals are always conducted by medical staff. Both ACA and NCCHC recommend that trained personnel conduct a complete health appraisal within 7 days after a juvenile has been admitted to the

facility. A facility is in conformance if it completed an appraisal within 7 days for the last 10 juveniles admitted to the facility prior to the survey or if an appraisal was transferred to the facility from another juvenile facility within 7 days of the juvenile's arrival.

Overall, 80 percent of confined juveniles receive health appraisals within 1 week of admission (Table 4B-1). Juveniles in reception centers are most likely to receive a health appraisal (93 percent), followed by training schools (82 percent), and detention centers (80 percent). Only 66 percent of juveniles committed to ranches received an appraisal. Juveniles in training schools are more likely to be appraised because they have been transferred from reception centers, where they received health and needs assessments.

Twenty percent of confined juveniles do not get health appraisals within 1 week. Fifteen percent are confined in facilities that require health appraisals, but at least 1 of the last 10 juveniles admitted did not receive an appraisal within a week (Table 4B-5). The period until an appraisal was completed was usually less than 2 weeks but could be a month or more in some facilities. Only 5 percent of juveniles are housed in facilities that do not perform a health appraisal at any time. Of these 5 percent, 2 percent were in facilities that provided no reason for not appraising juveniles; 1 percent were appraised prior to admission, but the facility never received the appraisal; and the remaining 2 percent were in facilities which stated that the length of stay was too short to warrant an appraisal. However, there was no statistically significant difference in juveniles' average length of stay between facilities that did and did not meet the health appraisal standard, regardless of facility type.

Table 4B-5

Percent of Juveniles in Facilities That Do Not Perform Health Appraisals Within 1 Week, by Reason for Not Requiring Appraisal and Facility Type

Reason for Not Performing Appraisal Within 1 Week:	Detention Centers N=20,003	Reception Centers N=2,618	Training Schools N=34,905	Ranches N=6,932	Total N=64,459
Performed within longer time period	11%	6%	16%	25%	15%
Not required	4%	1%	0%	1%	2%
Lack of funding	2%	0%	0%	0%	0%
Performed elsewhere, but not received within 1 Week	0%	0%	0%	7%	1%
Stay too short	3%	0%	1%	0%	2%

Source: Mail Survey, 1991

We collected data on some of the elements that a health appraisal may include. When we attempted to distinguish between appraisals for conforming and nonconforming facilities, we found no clear pattern. Nonconforming facilities are not more or less likely to include the elements on which we collected data. Table 4B-6 lists some of the elements that a health appraisal may include. As shown in the table, 79 percent of juveniles undergo a medical examination (blood pressure, temperature, etc.); 78 percent are asked to provide an alcohol or drug use history; 68 and 53 percent are tested for tuberculosis and sexually transmitted diseases (STD's), respectively; only 21 percent are tested for hepatitis; and 10 percent for HIV. With the exception of hepatitis and STD testing, juveniles in reception centers are more likely to have these procedures performed than are juveniles in other types of facilities. For example, over 98 percent of juveniles in reception centers receive a medical examination compared with an average of 79 percent across all facility types.

Table 4B-6

Percent of Confined Juveniles in Facilities Receiving Health Appraisals, by Recommended Elements and Facility Type, 1991

Health Appraisal Elements	Detention Centers N=20,074	Reception Centers N=2,618	Training Schools N=35,102	Ranches N=7,144	Total N=64,939
Review medical history	76%	98%	80%	75%	79%
Medical exam	86%	98%	86%	86%	86%
Record height and weight	88%	98%	88%	86%	88%
Review of health screening	84%	98%	80%	69%	81%
Alcohol use history	75%	97%	82%	62%	78%
Mental health a appraisal	61%	86%	67%	56%	65%
Drug use history	78%	94%	80%	62%	78%
Tuberculin test	56%	94%	73%	69%	68%
Test for hepatitis	16%	8%	23%	30%	21%
Tests for sexually transmitted diseases	46%	58%	60%	40%	53%
HIV/AIDS test	8%	26%	10%	13%	10%
Other	8%	10%	9%	7%	9%

Source: Mail Survey, 1991

These elements of the health appraisal appear to cover the most common health problems experienced by confined juveniles. The head of medical services at each of the 95 facilities visited was asked for the three most common medical problems seen among juveniles in their facility. Colds, eye, ear, and throat problems, respiratory problems, and injuries received both before and during confinement are very common among juveniles. We were told repeatedly during site visits that neglect and lack of prior health care contributed to many of the other health problems faced by juveniles in custody. With the exception of rare physical injuries, most juveniles do not appear to face serious medical problems, but their medical and personal care often has been neglected prior to confinement. Information from the health appraisal identifies the few juveniles who do require more intensive care.

One-half of confined juveniles are in facilities that perform both health screenings within 1 hour and health appraisals within 7 days of admission. Ninety-two percent of all confined juveniles get health screenings, but only 58 percent receive them within 1 hour of admission. Fourteen percent of juveniles, including one-third of those in detention centers, are held in facilities where screenings are conducted by staff who have not been trained by health care professionals. Only 5 percent of juveniles are not appraised, but 20 percent of juveniles are held in facilities that do not perform the health appraisal within 7 days. Most juveniles are held in facilities that include a medical exam, a review of medical history, and a review of the health screening in the health appraisal. A smaller proportion of juveniles are held in facilities that routinely test for STD's, tuberculosis, and hepatitis during the health appraisal.

Access to Information on Medical Services

Juvenile facilities are required to respond to any health problems identified in the health screening or health appraisal, or which arise during the period of confinement.[25] In larger facilities, there may be a specific time each week when juveniles may bring medical problems to the attention of staff. Smaller, less formal facilities may simply inform juveniles of the hours when medical staff are available. For example, the nurse may only come in on Mondays, and at other times sick or injured juveniles will be sent to the hospital. The ACA standard for this issue requires that a facility inform juveniles of the procedures for gaining access to health services. A facility is in conformance if juveniles are given this information during orientation at the time of admission.

Over 90 percent of confined juveniles are provided information about access to medical services during orientation (Table 4B–1). At least 90 percent of juveniles in detention centers, reception centers, and training schools receive this information, compared with 81 percent of juveniles admitted to ranches.

Sick Call

The ACA standard on sick call recommends that it be held once a week if the facility houses fewer than 50 juveniles, at least 3 days a week if it houses 50 to 200 juveniles, and 5 days a week if it houses more than 200 juveniles. A facility is in conformance if it holds sick call at least the number of days recommended for a facility of its size.

As shown in Table 4B–1, 90 percent of juveniles are housed in facilities that meet our sick call criteria. While over 90 percent of juveniles confined in training schools, reception centers, and detention centers are housed in facilities that meet the sick call standard, only 60 percent of juveniles in ranches have access to a sick call as often as required by the ACA standard. This likely is due to the high percentage of juveniles in ranches in which health care staff are never available (Table 4B–7).

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[25] According to case law, facilities must provide sick call, emergency medical and dental services 24 hours per day, and ongoing medical services (Soler, pp. 2–14 to 15).

A facility may provide access to medical staff without formalizing the process through a sick call. Eighty-four percent of juveniles are held in facilities that have a doctor or nurse scheduled daily, while most juveniles in other facility types have weekly access (Table 4B-7).[26] However, even on this measure of medical care, 24 percent of juveniles in ranches never have access to a medical staff member within the facility.

Table 4B-7

Percent of Juveniles With Access to Medical Staff by Type and Frequency of Staff Availability and Facility Type, 1991

Availability of Medical Staff	Detention Centers N=19,579	Reception Centers N=2,348	Training Schools N=33,869	Ranches N=5,741	Total N=61,538
Doctor and nurse scheduled daily	39%	60%	29%	0%	31%
Nurse or doctor scheduled daily	37%	34%	65%	48%	53%
Doctor scheduled less than daily	10%	1%	1%	7%	5%
Nurse scheduled less than daily	6%	1%	3%	17%	5%
Nurse or doctor on call[a]	4%	2%	0%	3%	2%
Health care staff never available	3%	2%	2%	24%	4%

Source: CIC Census, 1991

[a] Definition of nurse includes nurses, nurse practitioners, and physician assistants.

[26] These are the categories used in the CIC census. During the site visits, we asked for the number of days per week medical staff were scheduled. Approximately the same percentage of facilities responded that they had medical staff scheduled 5, 6, or 7 days per week. Of this group, one-third had medical staff scheduled 5 or 6 days per week and two-thirds had medical staff scheduled 7 days per week. Therefore, the 84 percent of juveniles held in facilities that have medical staff scheduled "daily" should be interpreted as juveniles held in facilities where medical staff are scheduled at least 5 days per week.

Table 4B-8 shows that most juveniles are held in facilities where the ratio of juveniles per medical staff member is between 11 and 50.[27] A substantial portion of juveniles held in training schools and ranches are in facilities where the ratio is over 76 juveniles per medical staff member. This may be a reasonable staffing level, however.

Table 4B-8

Percent of Juveniles in Facilities, by Ratio of Medical Staff to Juveniles and Facility Type

	Detention Centers N=14,648	Reception Centers N=2,113	Training Schools N=29,561	Ranches N=3,516	Total N=49,839
1:10 or fewer juveniles per medical staff	9%	4%	4%	3%	5%
1:11 to 1:25	42%	85%	22%	10%	30%
1:26 to 1:50	35%	6%	35%	19%	33%
1:51 to 1:75	10%	6%	14%	18%	13%
1:76 to 1:100	1%	0%	6%	20%	6%
Over 100 juveniles per medical staff	3%	0%	19%	30%	14%

Source: CIC Census, 1991

In summary, even though some facilities either do not formally tell juveniles about procedures for getting health care or do not schedule sick call as frequently as would be desirable, almost all juveniles outside of ranches seem to have access to routine care.

Written Arrangement for Emergency Care

The ACA standard recommends that facilities have written arrangements for emergency care. We considered a facility to be in compliance with this standard if it reported that such arrangements had been made.

[27] These ratios were computed by first constructing a full-time equivalent (FTE) number of staff in each facility from full- and part-time medical staff reported in CIC, where part-time staff were arbitrarily assigned a value of .5 FTE.

Conformance with this criterion is the highest of all of the health services criteria: Over 91 percent of each type of facility (confining 90 percent of all juveniles) have written arrangements for the provision of emergency care (Table 4B–1). In the 1-year period prior to the survey, approximately 90 percent of each type of facility had at least one juvenile who required emergency health care. Overall, the rate of emergency care use was 3 per 100 juveniles per year (Table 4B–9).[28] However, although juveniles appear to be at a lower risk for serious injury or illness in detention centers than in training schools or ranches, more incidents requiring emergency health care beyond first aid occurred in detention centers. The lower rate is due to the large number of admissions to those facilities in a 12-month period. The rate for detention centers and reception centers is significantly lower than that for training schools and ranches ($p \leq .05$), suggesting that juveniles in training schools and ranches may be at a greater risk of incurring serious injury or illness. There is no significant difference in the emergency care rate between facilities that did and did not conform to the written arrangements for emergency care standard.

Table 4B–9

Rate of Juveniles' Need for Emergency Health Care per 100 Juveniles Confined, Last 12 Months, by Facility Type

	Detention Centers N=527,730	Reception Centers N=19,642	Training Schools N=61,237	Ranches N=11,562	Total N=620,172
Juveniles needing emergency health care: rate per 100 juveniles	2	2	13	14	3
Number of incidents of emergency health care	8,809	393	7,865	1,580	18,647

Source: Mail Survey, 1991

Staff Training in First Aid and CPR

ACA requires that youth supervision staff be trained in first aid and CPR. A facility is in conformance with this standard if both new and veteran staff receive first aid and CPR training each year or are certified during their tenure.[29]

Almost 90 percent of juveniles are confined in facilities that are in conformance with this criterion (Table 4B–1). Juveniles in reception centers are the most likely to be confined in a conforming facility (99 percent), while juveniles in training schools are the least likely to be in a conforming facility (84 percent).

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[28] The mail survey asked for the number of incidents of emergency care used in the previous year. In computing the rate, we used the number of admissions recorded during the year.

[29] Some facilities or State systems provide their own training in first aid and CPR, but many require that staff acquire Red Cross certification prior to being hired and recertification every 3 years.

Summary Regarding Health Services

Although a majority of juveniles are held in facilities that meet the individual health services criteria, only 26 percent are held in facilities that conform to all of them. Of particular concern are health screenings and appraisals for all facilities and medical services as a whole for ranches. In detention centers particularly, health screening often is done by nonmedically trained staff. Timing is a problem for both health screening and appraisals. Many facilities perform these functions, but not quickly enough to meet the assessment criteria.

One-half of all juveniles are held in facilities that meet both the health screening and appraisal criteria. Only 38 percent of juveniles are held in training schools that meet both criteria. Training schools may be less likely to conduct screenings because they receive juveniles from within the juvenile justice system. Although juveniles frequently arrive with medical records, a health screening can detect changes in the juvenile's physical or mental health. In addition, a screening protects against lack of communication between staff at the sending and receiving facilities.

Although they do provide emergency medical care, a significant minority of ranches do not screen juveniles and never have medical staff at the facility. Forty-six percent of juveniles held in ranches do not receive a health screening within 1 hour of admission, 34 percent of juveniles confined in ranches do not get health appraisals within 1 week, and 24 percent never have access to medical personnel at the facility.

Facilities that do not have their own medical staff rely upon the nearest hospital or a local doctor. During a site visit, one ranch administrator acknowledged that limited access to medical services was a price that some ranches have to pay to operate a wilderness program and that the only solution would be to relocate the facilities closer to the nearest city—a move which would destroy the programs.

Facility directors of medical services in each type of facility reported that their biggest challenges in providing medical care are recruiting and retaining medical services staff. Some facilities have no special budget for medical services, cannot find medical staff willing to work with a confined juvenile population, or have difficulty finding qualified medical personnel for facilities located in remote areas.

Recommendations Regarding Health Services

We recommend that juvenile justice agencies act to ensure that initial health screenings are carried out promptly at admission by qualified staff and that health appraisals are conducted or received within 1 week of admission.

While health appraisals are always done by medical staff, initial health screenings are often carried out by nonmedical staff. This may be acceptable; however, more than one-third of juveniles in detention centers are in facilities where the nonmedical staff doing the initial screening have received no training from medical personnel on how to conduct a health screening. Because detention centers account for the vast majority of total admissions, this is a serious deficiency.

We recommend that juvenile justice agencies take steps to develop, and ensure the use of, an adequate training program for nonmedical staff who conduct health screenings.

We had no way to assess the adequacy of the health screening and appraisals or subsequent health services, since there is no systematic data base on the epidemiology of confined youths. Indeed, it appears that confined juveniles are often excluded from standard public health data collection.

We recommend that existing public health surveillance systems be expanded to include and separately track confined juveniles.

We also recommend a general review of the health and mental health needs of and services received by confined juveniles based on review of the medical and mental health records of a national sample of confined juveniles.

C. Food, Clothing, and Hygiene

Section C covers four assessment criteria: annual review of food allowance by dietitian, longest interval between meals, frequency of clothing exchange, and frequency of showers. It also contains ratings of food quality by both juveniles and site visitors.

This section discusses provision of adequate food, clothing, and sanitary facilities. Because juveniles are in a period of rapid physical growth, it is especially important that confinement facilities provide food that adequately meets their nutritional needs. Confined juveniles need to be provided clean clothing and be permitted to bathe frequently.

Constitutional standards have not been set on food service in juvenile detention and correctional facilities. However, trial courts have held that juveniles' menus should be prepared by or in consultation with dietitians or nutritionists[30] and that the menus should conform to appropriate nutritional standards.[31] Courts have held that facilities must provide three meals a day, plus an evening snack,[32] that special menus must be provided for juveniles with medical needs or religious requirements,[33] that food may not be withheld as punishment,[34] and that food service staff should meet applicable public health standards.

Courts have also held that juveniles should be provided with clean underwear and outer clothing on a regular basis.[35]

Nationally recognized standards also deal with these subjects. The ACA standard requires that facilities' dietary allowances are reviewed annually by a dietitian or physician to ensure compliance with such nationally recommended allowances as the Recommended Dietary Allowances, published by the National Academy of Sciences. ACA standards also require that the maximum time between an evening

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[30] *Julie* v. *Black*, Case No. 81-C-455 (W.D. Wisc, Mar. 29, 1982)

[31] *Terry D.* v. *Rader*, No. CIV-78-0004-T (W.D. Okla., Jan. 11, 1982)

[32] *Inmates of Boys Training School* v. *Affleck*, Civil No. 4529 (D.R.I., Jan. 15, 1979)

[33] *Ibid.*

[34] *Maldonado* v. *Ciuros*, 76 Civil 2854 (LWP) (S.D., N.Y., Aug. 29, 1978)

[35] *Inmates of Boys Training School* v. *Affleck*, (supra.)

meal and the following breakfast be no longer than 14 hours. Further, ACA standards require that juveniles receive clean underwear and socks each day and clean outer clothing twice a week.

Finally, ACA standards require that juveniles receive daily showers and showers after strenuous exercise.

In general, our assessment criteria are consistent with these ACA standards. However, our criteria for showers requires only that showers be provided daily. It does not require showers to be provided after exercise.

Table 4C-1 shows the percentage of juveniles in facilities that conform to each of these four criteria, as well as the percentage of juveniles in facilities that conform to all four.

The main deficiency among juvenile facilities is excessive waiting times between meals. Only 51 percent of all confined juveniles were housed in facilities where meals were no more than 14 hours apart, ranging from 42 percent of the juveniles in detention centers to 57 percent in ranches. On the other hand, 88 percent of all confined juveniles are in facilities that require an annual food allowance review by a dietitian or physician. Eighty-five percent of all confined juveniles reside in facilities that conform to the clothing exchange criteria, ranging from 70 percent in reception centers to 88 percent in training schools and ranches. Ninety-eight percent of all confined juveniles resided in facilities that provide at least one shower per day, and there was little variation by type of facility. Just 39 percent of confined juveniles were in facilities that conformed to all four criteria. Only 27 percent of juveniles in reception centers were in facilities that conformed to all four, compared to 31 percent in detention centers, 41 percent in ranches, and 44 percent in training schools.

The high incidence of excessive waiting times between meals appears to be less serious than it might seem. Excessive waiting times between meals almost always involve a wait of just over 14 hours between dinner and breakfast. While 49 percent of juveniles were in institutions where dinner and breakfast were more than 14 hours apart, only 5 percent were in institutions where the two meals were more than 15 hours apart, and less than 1 percent of juveniles had to wait more than 16 hours between dinner and breakfast.

During site visits, facility staff suggested the reason for this pattern of meal times. In many facilities, food service staff worked just one shift during the day, and serving times were compressed to fit their work schedule, resulting in early dinners, late breakfasts, or both and, consequently, a long interval between the evening and morning meal.

We did not ask interviewed juveniles if they got snacks before bed. However, observations during site visits suggest that facilities nearly always provided bedtime snacks in juveniles' living units. We have no information, however, on whether snacks are more substantial in facilities in which juveniles must wait more than 14 hours between meals.

Site visitors interviewed 475 randomly selected juveniles (5 at each facility). Site visitors asked juveniles to rate how important it was to have good food to eat, using a 5-point scale, where 1= "essential," 2= "very important," 3= "moderately important," 4= "slightly important," and 5= "not at all important." Overall, juveniles gave "good food to eat" a rating of 1.49 ($\pm$.22, .95 confidence interval), midway between "essential" and "very important."

Table 4C-1

Percent of Juveniles Confined in Facilities That Conform to Assessment Criteria on Food, Clothing, and Hygiene, by Facility Type

Assessment Criteria	Detention Centers (N=17,679 -20,074)	Reception Centers (N=2,552 -2,618)	Training Schools (N=29,299 -35,102)	Ranches (N=6,652 -7,180)	Total (N=56,182 -64,974)
Annual food allowance review[a]	**86%**	**89%**	**88%**	**88%**	**88%**
14 hours or less between meals[b]	**42%**	**56%**	**53%**	**57%**	**51%**
Clothing exchange[c]	**81%**	**70%**	**88%**	**88%**	**85%**
Daily showers[d]	**95%**	**100%**	**100%**	**100%**	**98%**
Percent of juveniles in facilities that conform to all criteria	31%	27%	44%	41%	39%
Conform to three criteria	50%	62%	41%	50%	46%
Conform to two criteria	13%	11%	14%	8%	13%
Conform to fewer than two criteria	6%	0%	0%	1%	2%

Source: Mail Survey, 1991

[a] For information on the percent of facilities in conformance, see Appendix E, Table E-10.
[b] For information on the percent of facilities in conformance, see Appendix E, Table E-11.
[c] For information on the percent of facilities in conformance, see Appendix E, Table E-12.
[d] For information on the percent of facilities in conformance, see Appendix E, Table E-13.

Site visitors also asked each juvenile to rate food quality at the facility on a 5-point scale, where 1= "outstanding," 2= "very good," 3= "satisfactory," 4= "needs improvement," and 5= "unacceptable." We do not know the standards of comparison juveniles used (for instance, whether they compared facility food to school cafeteria food, home-cooking, or to fast food, etc.). However, juveniles gave food in confinement facilities an average rating of 3.03 (±.10, .95 confidence interval), or just very slightly above satisfactory.

Site visitors ate three meals with the juveniles at each facility they visited and rated the food in terms of taste, temperature, and appearance using the same 5-point scale. On average, site visitors rated food taste, temperature, and appearance as "very good."[36]

The site visits also suggested that conformance with respect to clean clothing may be somewhat better than the mail survey indicates. In particular, it appears that some facilities that indicated that they provided clean clothing "as needed" are in conformance in practice.

Summary Regarding Food, Clothing, and Hygiene

Almost all confined juveniles are housed in facilities that conform to standards on clean clothing and daily showers. Almost 9 out of 10 confined juveniles reside in facilities in which menus are reviewed annually by a dietitian or physician. Although just one-half of confined juveniles are held in facilities in which the maximum duration between meals is 14 hours or less, the interval between meals seldom exceeds 15 hours. On average, juveniles rated food quality "satisfactory," and site visitors rated it "very good." Overall, conditions for confined juveniles relating to food, clean clothing, and personal hygiene appear to be good.

We have no recommendations for change.

D. Living Accommodations

Normalization is a major theme embodied in all sets of nationally recognized standards. Many aspects of normalization are covered in discussions on conformance measures in other sections of Chapters 4 through 7. For example, juveniles' ability to maintain contact with members of the community is covered in Chapter 7, Section A, "Access." This section describes elements of normalization which do not fit within other topic areas used to organize this report.

We identified four assessment criteria on living accommodations: (a) permission given to juveniles to wear personal clothing, (b) provision of furnishings (such as desks, chairs, etc.) in sleeping rooms, (c) permission given to juveniles to have personal items in sleeping rooms, and (d) amount of natural light provided in sleeping rooms. Table 4D–1 shows the percentage of juveniles in facilities that conform to each of these four criteria, as well as the percent of juveniles in facilities that conform to all four.

Overall, 72 percent of confined juveniles are in facilities that permit them to wear some personal clothing items. The large majority of juveniles in training schools and ranches can wear clothing items of their own, but just 41 percent of those in detention centers and 55 percent of those in reception centers are permitted to do so.

Seventy-nine percent of juveniles are in rooms with furnishings other than a bed and mattress (that is, items such as desks, chairs, bureaus, etc.). Only 43 percent of those in detention centers have such items in their sleeping rooms, compared to 90 percent or more in the other facility types.

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[36] Average site visitor ratings were:

- Taste: 1.90, ±.24
- Temperature: 2.02, ±.23
- Appearance: 1.97, ±.23

Overall, 96 percent of confined juveniles are permitted to have some personal items in their sleeping rooms, such as books, portable radios or stereos, posters, photographs, etc. Reception centers had the smallest proportion (87 percent) of juveniles permitted to have such items.

Table 4D-1

Percent of Juveniles in Facilities That Conform to Assessment Criteria on Living Accommodations, by Facility Type

Assessment Criteria	Detention Centers N=18,322 -20,074	Reception Centers N=2,515 -2,618	Training Schools N=32,170 -35,102	Ranches N=6,047 -7,180	Total N=59,054 -64,974
Personal clothing[a]	**41%**	**55%**	**88%**	**90%**	**72%**
Furnishings in sleeping room[b]	**43%**	**90%**	**95%**	**99%**	**79%**
Personal items in sleeping room[c]	**95%**	**87%**	**97%**	**100%**	**96%**
Natural light in all sleeping rooms[d]	**68%**	**89%**	**82%**	**91%**	**79%**
Percent of juveniles in facilities that conform to four criteria	15%	49%	68%	80%	52%
Conform to three criteria	38%	31%	28%	18%	30%
Conform to two criteria	25%	10%	3%	3%	10%
Conform to one criterion	23%	9%	2%	0%	8%

Source: Mail Survey, 1991

[a] For information on percent of facilities that conform, see Appendix E, Table E-14.
[b] For information on percent of facilities that conform, see Appendix E, Table E-15.
[c] For information on percent of facilities that conform, see Appendix E, Table E-16.
[d] For information on percent of facilities that conform, see Appendix E, Table E-17.

Seventy-nine percent of confined juveniles are held in facilities in which all sleeping rooms have natural light provided by windows or skylights. Juveniles in detention centers were least likely (68 percent) to be in facilities in which all sleeping rooms had natural light.

Just 52 percent of confined juveniles are in facilities that conform to all four criteria. Only 15 percent of juveniles in detention centers are in facilities that conform to all four, compared to 49 percent in reception centers, 68 percent in training schools, and 80 percent in ranches.

As would be expected, furnishings and personal items are less likely to be allowed in rooms used to isolate juveniles (Table 4D–2). Still, one-third of confined juveniles are in facilities that provide furnishings (other than a bed) in isolation rooms, and 79 percent are in facilities that permit juveniles to have personal property in isolation rooms. In facilities where most juveniles sleep in single rooms, if isolation is imposed, it frequently is carried out in the juveniles' regular sleeping rooms. Hence, the relatively high rate of personal items reported in isolation rooms is an artifact of that practice. During site visits, special rooms used only for isolation usually were austere and devoid of personal items.

Table 4D–2

Percent of Juveniles in Facilities Allowing Furnishings and Personal Items in Isolation Rooms, by Facility Type[a]

Items Permitted	Detention Centers N=13,193–14,404	Reception Centers N=1,961–2,044	Training Schools N=23,830–25,396	Ranches N=1,528–1,299	Total N=40,512–43,143
Furnishings in isolation room	33%	0%	37%	16%	33%
Personal items in isolation room	70%	93%	84%	75%	79%

Source: Mail Survey, 1991

[a] Includes only facilities that have isolation rooms.

Clothing

The mail survey collected information on whether clothing is provided by the facility or the juvenile. Diversity of clothing is a second important issue. While we can assume that clothing will be diverse when juveniles provide some or all of their own clothing, we cannot assume the opposite: that when facilities provide all clothing, it will be uniform. Indeed, during pretests and site visits, we observed that some facilities provided diverse clothing to juveniles and others provided uniform clothing.

Advocates of normalization urge that confined juveniles should be permitted to wear their own clothes or clothing provided by the facility that is similar in style, fit, and diversity to that worn by children in the community. However, officials sometimes cite concerns for safety and control as reasons

for requiring uniform dress. The style, color, brand, or manner in which clothing is worn often are used as gang signals.[37]

Site visitors recorded their observations on the diversity of clothing worn by juveniles at each facility they visited. In the detention centers visited, juveniles typically wore uniform clothing; however, in most training schools, reception centers, and ranches, juveniles were clad in diverse attire.[38] Based on site visitor observation, we estimate that 27 percent (±9 percent) of confined juveniles are clad in uniform attire, 28 percent (± 9 percent) are clad in uniform attire with some diversity, and 45 percent (± 10 percent) are clad in diverse attire.

During site visits we asked 475 randomly selected juveniles to rate the importance of 17 items, including "being able to wear what you want." Juveniles used a 5 point scale, where 1= "essential," 2= "very important," 3= "moderately important," 4= "slightly important," and 5= "not at all important." Overall, juveniles gave a rating of 1.75 (±.22) to "being able to wear what you want."

Juveniles also were asked to rate the facilities' performance in letting them wear what they wanted, using a similar 5-point scale, where 1= "outstanding," 2= "very good," 3= "satisfactory," 4= "needs improvement," and 5= "unacceptable." Their responses mirrored site visitor observations. Their average ratings (and the 95 percent confidence intervals) were:

Detention centers	4.18 (± .18)
Reception centers	3.36 (± .43)
Training schools	2.86 (± .20)
Ranches	1.84 (± .16)

On average, juveniles rated training schools, reception centers, and ranches as "satisfactory" or better, while they rated detention centers as "needing improvement."

During site visits we observed some facilities in which staff deliberately issued ill-fitting clothes to juveniles. One detention center administrator said ill-fitting clothing was part of a concerted effort to make the juveniles uncomfortable enough that they would not want to return to his facility. We observed

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[37] For example, brands of sneakers are a commonly used gang signal. Even when facilities provide all clothing worn by juveniles, clothing is frequently used to communicate gang membership. For example, the way in which cuffs of pants are folded, the direction (frontwards or backwards) or angle at which hats or caps are worn, etc., are used to identify the wearer as a member of a particular gang.

[38] Site visitors used the following scale to rate diversity in clothing:

1 = uniform dress (no diversity),
2 = uniform dress with some diversity, and
3 = diverse dress.

On average ratings for the different types of facilities are:

Detention centers	= 1.23 (± .02);
Reception centers	= 1.71 (± .15);
Training schools	= 2.56 (± .02); and
Ranches	= 2.66 (± .03).

other facilities where staff used diversity of clothing as a positive incentive to support control objectives: As juveniles earned points for good conduct, they could use those points to "purchase" a wide variety of T-shirts, sweatshirts, and other diverse clothing from the facility commissary.

Contents of Sleeping Rooms

Another element of normalization that relates to the furnishings provided in sleeping rooms and to whether juveniles are permitted to keep personal items in their sleeping rooms is what furnishings are provided and what personal items are permitted in juveniles' sleeping rooms.

a) Furnishings

All juveniles are in facilities that provide beds and mattresses, and nearly all are in facilities that provide sheets. Thereafter, the amount of furnishings in juveniles' rooms drops sharply. Table 4D-3 describes furnishings in juveniles' sleeping rooms by type of facility. Overall, 57 percent of juveniles' rooms contain a desk and just 54 percent have a chair. Forty-four percent of juveniles have a closet or bureau and 40 percent a locker for storage of clothes or belongings. Forty-three percent of juveniles have toilets in their sleeping rooms (mostly in rooms designed to house just one juvenile).

Table 4D-3

Percent of Juveniles in Facilities That Provide Furnishings in Sleeping Rooms, by Facility Type

Types of Furnishings	Detention Centers N=19,401-19,815	Reception Centers N=2,538	Training Schools N=33,575-34,767	Ranches N=6,601-6,718	Total N=62,143-63,839
Desk	34%	50%	72%	52%	57%
Chair	23%	24%	73%	58%	54%
Closet/bureau	3%	21%	66%	64%	44%
Locker	3%	66%	53%	68%	40%
Reading lamp	14%	12%	34%	41%	28%
Toilet	60%	70%	32%	37%	43%

Source: Mail Survey, 1991

Training schools provide more furnishings in sleeping rooms than detention centers do. For example, 72 percent of the training school population have desks and 73 percent have chairs, while just 34 percent of the detention center population are provided with a desk and 23 percent with a chair. Sixty

percent of juveniles in detention centers have toilets in their sleeping rooms, compared to just 32 percent of those in training schools.[39]

b) Personal Items in Sleeping Rooms

Table 4D-4 describes the types of personal items that different types of facilities allow in juveniles' sleeping rooms. Overall, 94 percent of juveniles are allowed to have books in their sleeping rooms, 92 percent allowed magazines, and 89 percent allowed photographs. Eighty-four percent of juveniles can have clothing in the sleeping rooms, while 69 percent may have posters and 60 percent may have radios or stereos. Training schools are most likely to permit this range of personal items in juveniles' sleeping rooms, while detention centers are least likely to permit them.

Table 4D-4

Percent of Juveniles in Facilities That Allow Personal Belongings in Sleeping Rooms by Facility Type

Types of Personal Belongings	Detention Centers N=19,553-20,038	Reception Centers N=2,595-2,618	Training Schools N=33,768-34,446	Ranches N=6,691-7,015	Total N=62,954-64,078
Books	90%	87%	96%	99%	94%
Photographs	74%	87%	97%	95%	89%
Clothing	61%	88%	95%	98%	84%
Magazines	88%	87%	94%	99%	92%
Posters/photos	44%	50%	85%	69%	69%
Radios/stereos	23%	74%	82%	59%	60%

Source: Mail Survey, 1991

During site visits we observed that in extremely crowded open dormitories, juveniles were permitted to have fewer personal items. In the most crowded dormitory we observed—which had an average of just 22 square feet per juvenile—no personal items of any sort were permitted.

[39] Normalization advocates argue against toilets in sleeping rooms, since few, if any, persons in the free community sleep in a room which contains a toilet.

Access to Natural Light in Sleeping Rooms

Except for detention centers, it is rare that juveniles are held in facilities in which no rooms have access to natural light (Table 4D–5). Overall, 7 percent of confined juveniles are held in facilities in which some of the sleeping rooms do not have natural light; 16 percent of juveniles confined in detention centers are held in facilities in which none of the sleeping rooms have natural light; and 93 percent are held in facilities in which all sleeping rooms have some natural light or transparent windows with an exterior view.

Table 4D–5

Percent of Juveniles in Facilities Where Sleeping Rooms Have Access to Natural Light, by Facility Type

Source of Natural Light in Sleeping Rooms	Detention Centers N=19,932	Reception Centers N=2,618	Training Schools N=35,102	Ranches N=7,180	Total N=64,832
None, only artificial light	16%	1%	3%	3%	7%
Some natural light[a]	16%	10%	14%	6%	14%
Transparent windows	68%	89%	82%	91%	79%

Source: Mail Survey, 1991

[a] Includes translucent windows, sky lights, and windows positioned so that no exterior view is possible.

Summary of Living Accommodations

Living accommodations related to personal clothing, room furnishings, personal items in rooms, and access to natural light seem good, particularly in long-term facilities (training schools and ranches). Most juveniles in those facilities can wear personal clothing and have a variety of furnishings in their sleeping rooms. Almost all juveniles in all facilities can have some personal items in their sleeping rooms. Except in detention centers, very few juveniles are confined in sleeping rooms that do not have natural light. To the extent that some juveniles are held in detention centers for longer periods—for example, for a postadjudication sentence or awaiting waiver to the adult courts[40]—the absence of normalizing practices and the higher percentage of juveniles held in rooms without natural light may be more serious.

We have no recommendations for change.

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[40] During a visit to one large detention center, staff informed us that one juvenile had been confined there for 735 days pending conclusion of appeals on a petition to waive him to adult court. In this particular facility, almost 20 percent of the population were juveniles who were being waived for prosecution as adults.